

The Air Carrier Access Act: Protecting the Civil Rights of Airline Passengers with Disabilities

Abstract

This Web cast will provide a brief overview of the Air Carrier Access Act of 1986, which prohibits discrimination against individuals with disabilities in commercial air transportation, and its implementing regulation, 14 CFR Part 382 (Part 382).

It will include discussion on:

- Major provisions of Part 382 and its amendments since being implemented in 1990;
- A summary of the Department's disability-related initiatives within the last few years in three basic areas:
 - Investigations and Enforcement,
 - Rulemaking, and
 - Outreach and Public Education.
- Types of complaints received by the Department of Transportation (DOT) from passengers with disabilities
- DOT's complaint-handling process

The Air Carrier Access Act: Protecting the Civil Rights of Airline Passengers with Disabilities.

Presenter: Mike Spollen

Transcript of Web case

TAJAUNA: Good afternoon, everyone. And welcome to the web case the Air Carrier Access Act: Protecting the civil rights of airline passengers with disabilities. My name is Tajauna Arnold with ILRU and I will be moderating today's web case and voicing your questions to the presenter. You can submit questions any time throughout this web case, however, I want to encourage you to submit questions you may already have at the beginning of this web case. You can submit questions by clicking the submit question button at the bottom of your RealOne Player screen or simply address it to web_case@ilru.org. Questions will be posed to the presenter upon the presenter's request. Additionally, if anyone has technical difficulties during this web case, please call us at (713)520-0232 and dial 0 for the operator. This number is both voice and TTY capable. As previously mentioned, today's web case is the Air Carrier Access Act: Protecting the civil rights of airline passengers with disabilities. It is being presented by Mike Spollen, who is a native of the Washington D. C. area. After attending Virginia Tech and graduating from George Mason University, Mike began his federal career as an investigator in 1979 with the Civil Aeronautics Board. There he investigated potential violations of airlines by various consumer protection regulations and was involved closely in a development and implementation of the first federal regulation protecting the rights of airline passengers with disabilities. Mike says that he has finally gotten over the fact that after Congress realized that the Civil Aeronautics Board had hired him, it quickly passed sunset legislation closing that agency at the end of 1984. Not to be deterred, Mike transferred from the Civil Aeronautics Board to the Department of Transportation where he currently works in the general counsel's Aviation Consumer

Protection Division. Since passage of the Air Carrier Access Act in 1986, Mike has been actively involved in DOT's efforts to protect the civil rights of airline passengers with disabilities and ensure airlines' compliance with DOT's Air Carrier Access Act regulations. Mike currently serves as the Department of Transportation's aviation disability team leader, where he helps coordinate the department's rule-making, investigative and enforcement activities. And with that, Mike, I turn the web case over to you.

MIKE: Thanks a lot, Tajauna. Hello everyone. Hey, since I understand this is being broadcast all over the entire world, when I'm done does this mean I'm an international man of history like Austin powers?

TAJAUNA: Yes, it does. It is being archived, so you will forever be an international man of mystery.

MIKE: That's fitting to my past life. In any event I appreciate very much as Tajauna just mentioned I work at DOT and their headquarters office in Washington D. C. And I'm part of the general counsel's enforcement office and more specifically within that office I work in the Aviation Consumer Protection Division and I guess our office is probably best known as the office that attempts to resolve airline passenger's service related complaints against airlines. We're sometimes confused with the federal aviation administration or the FAA which is probably a better known entity. The primary distinction between our role and that of the FAA is that the FAA handles safety issues whereas my office handles the service related issues we received from the public. The Secretary of Transportation and the department as a whole are very concerned about ensuring the civil rights of airline passengers with disabilities and for that reason, complaints involving passengers with disabilities and disability issues in general for that matter are given a very high priority within the department. Just as a quick sidebar as many of you may know, former Secretary of Transportation, Norman Minetta who was one of the principal authors of both the Air Carrier Access Act and the Americans with

Disabilities Act departed DOT on July 7th of this year after serving for over five years. Our current acting secretary is Maria Fino and President Bush has recently announced the nomination of Mary Peters who was with the former Highway Administration to serve as the 15th secretary of transportation. Having said that, I forgot to mention that I do a little public speaking occasionally and they let me out of my office, but I talk a little quickly so for the captioner there, if I happen to be rambling on too quickly, by all means let me know and I'll try to slow down, but the good thing is most captioners get to submit a bill for double time after having to type the stuff I say. Please slow me down if I'm going too quickly. I love hearing myself talk so I get a little excited. In any event, I'd like to talk a little bit about the Air Carrier Access Act and then maybe give some specifics as they relate to the disability-related activities of the office I work in. And I'll then be happy to answer any questions that folks might have. Having done a few of these, I'm happy to try to field questions on the fly as I do it, although it's been my experience it might be better to wait until the end of my little -- I've got a few notes here I'd like to go through and it might be that before you ask the question I might go over the issue that you have in mind so it might be better to wait for the questions until after I'm done with my little spiel here, but having been married twice I'm very familiar with being interrupted constantly. If you want to send an E-mail through while I'm talking, feel free and Tajauna will decide whether I will answer. The Air Carrier Access Act was signed into law by then President Reagan in October of 1986. And the Air Carrier Access Act or ACAA as I will probably start referring to it prohibits discrimination against individuals with disabilities in commercial air transportation. The Air Carrier Access Act is sometimes confused with the Americans with Disabilities Act, which was signed into law by then President Bush in July of 1990. So that again came four years after signing the Air Carrier Access Act. Again, in very brief terms, the primary distinction between the Air Carrier Access Act and the Americans with Disabilities Act is that

the former law prohibits discrimination by airlines against passengers with disabilities, whereas the Americans with Disabilities Act prohibits discrimination in other modes of transportation, for example, subways, bus systems, et cetera. In any event, the Air Carrier Access Act prohibits discrimination against airline passengers with disabilities. The act is intended to remove the nonsafety related barriers both physical and attitudinal for that matter to air travel by people with disabilities. The act is intended to ensure that passengers with disabilities enjoy equal access to the nation's air transportation system and are afforded the safe and dignified service that they all that they and all others expect and deserve. The act and the implementing regulation which I will refer to as 382 is meant to remove the hassle and stress that is sometimes encountered by folks with disabilities prior to its passage. Forgive me if I refer to parts 382, that's just my summary for the regulation itself is 14 CFR Part 382, but since I can't repeat that too often without messing it up, I'll refer to 382 which is the regulation implementing the Air Carrier Access Act. Again, it's been about 20 years since passage of the Air Carrier Access Act itself in 1986 and 16 years since DOT adopted the final regulation which implemented it, which as I said is Part 382. Part 382 of the regulation we think represents a major stride forward in improving air travel for folks with disabilities and protecting their civil rights. Our rule we think clearly explains the responsibilities of the air traveler, the airlines, the airports and the contractors that collectively make up a system that moves over a million airline passengers each day. As a preliminary matter, it might be good for me to define what the heck is a disabled individual, who is covered by our regulation? Our disability rule essentially defines an individual with a disability as an individual who has either a physical or mental impairment that are either a permanent or temporary basis substantially limits a major life activity. By a major life activity, I mean something very basic like caring for yourself, performing manual tasks, walking, seeing, hearing, speaking, breathing,

learning, and even working, all could be considered major life activities. Very briefly about did requirements of the act and the rule itself and I'll try to be brief because it's about a 15 page rule and kind of complex. I like it that way. It's job security for me to get on these things occasionally and explain what the heck it means, in any event, among numerous requirements of the rules, some of the fundamental services that are required by the act and the incoming rule is that it requires carriers to provide on request assistance to passengers with disabilities with enplaning, deplaning, making connections with an airport to get to a connecting flight, to transport wheelchairs and other kinds of assistive devices. They must provide the packaging for powered wheelchair and devices similar to that and package the batteries to return such devices promptly to passengers upon arrival after a flight lands and also provide special seating accommodations for folks in certain situations. An example of such a seating accommodation that comes to mind would be a bulkhead seat for a passenger traveling with a service animal or perhaps a seat in a row with a movable arm rest for a nonambulatory passenger who requires the use of an aisle wheelchair to board the aircraft. Those are a couple of examples of the types of seating accommodations we would require. Carriers are not allowed to charge for any of the accommodation that is are required by our rule such as those services I just mentioned and for things like hazardous materials packaging for wheelchair batteries but they may charge for optional services such as provision of inflight medical oxygen. Carriers also have to allow for the stowage of wheelchairs and other devices in the passenger cabins provided it's done consistent with FAA safety considerations and they cannot count an assistive device against the carry on total normally allowed for other passengers. Additionally, airlines may not limit their liability for damage to a wheelchair or other assistive device on a domestic flight, which I think is a kind of cool thing and they are prohibited from requiring a passenger with a disability to travel with an attendant except in very limited circumstances based on safety

considerations. Airlines must also permit passengers with disabilities who travel with service animals in the cabin in most circumstances. Not to be too technical, but real quickly, there are some technical requirements about aircraft themselves. Our rule Part 382 requires what we define new aircraft and that if I recall off the top of my head is an aircraft that is ordered by an airline after April 5th of 1990 or delivered to the airline after April 5th 1992. The rule requires those aircraft that I'll refer to hereinafter as a new aircraft to have physical accessibility features, for exam, a new aircraft with 30 or more seats has to have movable aisle arm rests on half the aisle seats. New twin-aisle aircraft have to have accessible lavatories and new aircraft with 100 or more seats have to have a priority stowage space in the cabin to stow a passenger's personal folding wheelchair. And in addition, aircraft other than new aircraft that have more than 60 seats have to have a place on board to put an on board aisle chair on a flight with a passenger gives the airline at least 48 hours notice that he or she could use an inaccessible lav but needs help getting from the seat to the bathroom. Our rule Part 382 also requires airlines to provide training to the customer contact personnel and the requirements of the Air Carrier Access Act and it states that carriers must make available a complaint resolution official or CRO to respond to complaints from passengers with disabilities so, again, if there is one tip that I'd highly recommend that listeners glean from this little talk I'm giving, it's the term CRO. Pair pier a CRO or complaint resolution official is someone who is conversant with the rule and knows what the requirements of the rule are and will be able to react in a realtime basis to any complaint or request for an accommodation from an individual with disabilities. So again, Tajauna, what does CRO stand for? Are you taking notes?

TAJAUNA: I was just about to write it down.

MIKE: It stands for complaint resolution official. And if I ask you what a B.L.T. stood for, what would you say? That's a bacon, lettuce, tomato. I know this is dry stuff. In any event, seriously, if

you are ever in an airport situation and you need help with a disability-related issue, please ask the airline to provide a CRO or complaint resolution official and that will really help expedite, we hope the resolution of your problem.

TAJAUNA: Quickly, the CRO, whenever they ask for one, is this someone who is there within the airport or where?

MIKE: Essentially I to answer your question, yes, the airlines make available on request in a fairly prompt manner a CRO in real life what most carriers do is they train customer service supervisors, station managers and folks such as that that work for the airline familiar with our rule and designated as CRO's so in most cases at each airport there is one or more CRO physically available to discuss disability issues consumers, but the airline would in fact be in compliance with our rule if they simply made the CRO available via telephone in a fairly timely manner at no cost to the public. So if you happen to be for some reason you came in at eleven o'clock at night to an outlying station like Mason City, Illinois, and they probably don't have people there at that late night, they'd still have to make one available from the headquarters via telephone. Most cases you'll have an actual human being to react to the issue in the airport itself.

TAJAUNA: Good to know. Thank you.

MIKE: What does that mean?

TAJAUNA: Complaint resolution officer.

MIKE: Official. In any event, our rule also requires airlines to provide to consumers who write a written complaint, it requires them to provide a dispositive written complaint to the consumer that addresses the issues. I'll dare you to find the word dispositive in addiction Nary. It response a response that fully addresses all the issues raised by the consumer and a concluding letter whether the carrier thinks they did or didn't violate the rule. And what action might be taken. So in any event, since the adoption of the original ACAA regulations in 1990 the department issued several amendments to the ruse which we think are intended to further

enhance the accessibility of the transportation system. The rule is kind of a living, breathing document which changes ten times since we put it out on the streets in 1990 as new issues come up and as people bring to our attention things they think are not super clear or we didn't address at all. We will add amendments to the rule after doing a rule-making how that whole process works, but we're constantly enhancing, amending the rule to make it easier to understand, we hope, and to increase accessibility to folks with disabilities getting on and off planes is basically the intent of it. I'll go over real quickly some of the major amendments since 1990 to the rule. In November 1996 we amended the rule to require boarding list of aircraft with the compass I have 19 through 30 seats. There are certain aircraft that are exempted from the requirements. Off the top of my head there are various ones. All three of those aircraft type are 19 seat aircraft where there are problems either literally get something one in an aisle chair down the aisle of the aircraft or deploying the lift itself without a direct threat to puncturing the fuselage of the plane. In most cases, the 19 through 30 seaters if they don't have entry level boarding have to have a lift to get folks who are nonambulatory from the tarmac level up to the door of the plane to get to their seat. Another significant rule that we added an amendment to the rule was in March of 1998. We amended the rule to clarify that in addition to following the other specific provisions of Part 382, carriers can arguably be asked to modify policies and practices and facilities to ensure nondiscrimination consistent with the standards in Section 504 of the Rehabilitation Act, unless such a modification would impose an undue burden or fundamentally alter the nature of the program that the carrier provides. So in other words, in layman's terms that even I can understand, the carriers could arguably be asked to do anything that an individual asks them to do even if it isn't specifically enumerated in the regulation unless doing so could be shown to be an undue burden to the aircraft.

TAJAUNA: Mike, if I could get you to slow down just a bit for the captioner.

MIKE: Okay.

TAJAUNA: Thank you.

MIKE: I'll do my best. Also in March of 1998 we amended the Air Carrier Access Act rules to establish specific procedures for providing seating accommodations for folks with disabilities. An example of a required seating accommodation on request would be a bulkhead seat for a passenger traveling with a service animal or a seat in a row with a movable aisle arm rest as I think I alluded to earlier for a passenger who is totally nonambulatory and requires enplaning assistance using an aisle chair otherwise known as a boarding chair. Those are just some examples of the kinds of seating accommodation that is are now mandated by the regulation. As I also alluded to earlier, I think, on August the 2nd of 199 we amended the Air Carrier Access Act regulation Part 382 by eliminating the liability limit for lost, damaged or delay to wheelchairs and other assistive devices on domestic flights, and we think that that particular amendment provides a strong incentive, an economic incentive for airlines to treat assistive devices with care and to ensure that they are returned to the passenger in the condition in which they are received as required by the rule. Because after all, in many cases, someone's cane, crutches, wheelchair, is in fact their very mobility and without them it makes it incredibly inconvenient when you arrive at your destination and your wheelchair doesn't function properly. So we think removing the liability limit hopefully makes the carriers do an even better job making sure these things are returned to folks in a good condition. On May the 3rd of 2001, DOT issued another amendment to our rule that requires a lift to board aircraft larger than 30 seats. I mentioned earlier we had done one that would require lifts for aircraft with 19 through 30 seats. We issued kind of a similar rule that covers the bigger planes, the 31 and above aircraft capacity planes. As I said, it's real similar to the one with the 19 through 30

seats, but we think together the two lift amendments should go a long way toward eliminating the problems we were hearing about from folks who were nonambulatory who were subjected to the formerly acceptable practice of being lifted from the tarmac level to the door of the aircraft in a boarding chair which many folks understandably considered to be an undignified and unsafe sometimes manner of boarding and deplaning. So essentially whenever there is not level entry boarding, and by that I mean one of those gizmos that what we call a jet bridge or jetway, if they don't have one of those available, in most instances airlines have to ensure some form of level entry boarding that does not require them to put you in a straight backed chair or a boarding chair and physically lift you up to the plane. You would be transferred. You would be transferred from perhaps your personal wheelchair into a boarding chair that would be rolled on to the lift. The lift would then be hoisted up the ten or 15 feet to the level of the plane and you are rolled off that to your seat which we think is a much safer and more dignified way of getting folks on and off aircraft. As it relates to amendments, in 2003 I believe it was, DOT issued another amendment to our rule that requires both U.S. and foreign airlines that operate flights into and out of the U.S. to record and categorize complaints that they received directly from passengers with disabilities alleging inadequate accessibility or discrimination and in fact to report those complaints each year to DOT where I work. And then I get the lovely task of reading them all. In any event, this is the only provision in our current rule that applies to both U.S. and foreign carriers. Again, that is the requirement that aircraft -- that airlines that operate flights into and out of the U.S. have to capture complaints from folks with disabilities and report that data to DOT. We then in turn the department summarizes the data and sends a summary report over to Congress, which summarizes the data. We in fact have done that and we've submitted one report to Congress that covers the complaints that the airlines received for calendar year 2004. And we're currently finalizing our second report to

Congress that concerns the data we received from the airlines for the calendar year 2005. Again, not to be too confusing, but that's what I'm good at, when initially it was passed into law, the Air Carrier Access Act applied only to U.S. carriers. However, on April the 5th of 2000, Congress passed a law called the Wendal Ford Aviation Investment and Reform Act for the 21st Century, otherwise known as AIR 21, which extended the applicability of the Air Carrier Access Act itself to foreign airlines as well. We're currently working on a rule-making, what we call an N. P. R. M. or notice of proposed rule-making -- and Tajauna, I am going to quiz you on all of these acronyms. These are all going to be on the quiz.

TAJAUNA: I know I'll get one out of three. It would be the B.L.T.

MIKE: At least two out of three would be a bureaucrat like I am. This rule-making is going to extend the applicability of the underlying regulation, the really detailed 15 page regulation to cover the foreign carriers of the world that operate into and out of the U.S. So that's a very significant rule-making we're working on and it's really going to, we think, enhance the accessibility for disabled folks all around the world now, not just in the American transportation system. Most of the provisions in the current rule that apply now simply to the U.S. carriers will apply to the foreign airlines that operate into and out of the U.S. and to the coach airlines that the foreign airlines operate in conjunction with their U.S. partners. That's kind of a little bit about the Air Carrier Access Act. When it came into being, what the heck it does, what it requires. I'd like to talk a little bit now on some general stuff on complaint trends in my office. We think at least in our view that airline passengers with disabilities have experienced fewer difficulties in gaining access to the nation's air transportation systems since passage of the Air Carrier Access Act. And instances of bad treatment of disabled folks seem to occur less frequently than prior to its passage in 1986. I think probably as airlines have become more aware of the need to provide service to people with disabilities and have trained their contact employees in

the best techniques and procedures for accommodating their needs, many of the common problems that had formerly confronted disabled travelers have been minimized and in some cases eliminated altogether. For example, we don't hardly ever receive complaints involving issues such as a flat out refusal to board a passenger with a disability or forcing a passenger with disability to travel with an attendant at least when it's not allowed by our rules or refusal to permit the service animal to travel in the passenger cabin or refusal to transport a wheelchair or other assistive device. So we feel the disabled travelers have significantly benefited from the act itself and the underlying rule. Having said that, airline passengers with disabilities still encounter problems and we still receive a significant number of disability complaints in my office. For example, since 2000, DOT has averaged between about 400 to almost 700 disability-related complaints each year, which we receive directly at the department and that averages about 3 percent to 6 percent of the total service-related airline complaints we receive at DOT it's our understanding many speaking with airlines that they receive a significantly bigger number of complaints directly from consumers. I don't know the exact number. I've heard quotes of something like 50 times as many but I don't have any specific data on that, but while the number of complaints received in my office may seem small in comparison to those that the airlines themselves get, we think we have a sufficient number of complaints to enable us to at least track trends and problem areas and to otherwise identify situations in which airlines policies and procedures may need to be corrected in order to assure compliance with our rule. In that regard, whenever our review of even one disability complaint indicates that a carrier's policy or procedure is not in compliance with Part 382 or the act as it relates to foreign airlines, we in fact immediately contact the carrier to ensure prompt corrective action and that's a fairly effective program. With regard to complaint handling process itself, which is something that I kind of am involved in every day, briefly, whenever

DOT receives a written complaint involving a disability-related issue, we conduct a thorough investigation of the individual complaint. That process essentially consists of sending an acknowledgment letter to the passenger or complainant, we then send a referral letter with a copy of the complaint to the appropriate airline and we ask the carrier to review and respond directly to the complainant, but providing DOT a copy of the response. And then my office, in conjunction with some enforcement attorneys, does a legal analysis of the complaint and the airline's response to determine if in our view the carrier's actions did or did not constitute a violation of our disability rule or the intent of the Air Carrier Access Act. After that legal determination has been made, we then send a letter summarizing the results of the investigation to the consumer and explaining what action we intend take as a result of our investigation. Such actions could include sending a warning letter to the involved airline if it appears as though they may be in violation of our rule. If it's appropriate or considering perhaps more formal enforcement action if we uncover a pattern or practice of noncompliance with our rules or if a particular incident constitutes a really bad violation of Part 382 or the ACA pavement. As I've mentioned in all cases if we determine that an airline has a policy or procedure that might affect other folks with disabilities down the road that's not in compliance with our rules, we contact the airline as quickly as possible and work with them to ensure that prompt corrective action is taken by the carrier. Roughly, one-third to one-half of the complaints that DOT receives involve potential violations and by that I'm talking about if a complaint alleges an activity that's inconsistent with our rules and the carrier doesn't refute or deny the allegation, we arguably might have a disability violation to contend with. The vast majority of the potential violations fall into about four basic categories, just looking back at my notes here, those would be, number one, failure to make wheelchairs available in an untimely fashion to deplane passengers with mobility impairments. I think that generates about at least 50 percent of the complaints

DOT receives directly from the public about disability issues. About half of them have to do with folks who have difficulties getting on and off of aircraft because of mobility problems. It's a difficult thing to do, but it's required under our rule and we get an awful lot of complaints indicating that on occasion carriers don't do it at least to the satisfaction of the traveling public. The second complaint generated would be fair to deplane someone in a timely fashion. We still occasionally receive complaints concerning folks with reduced or limited mobility who are left on board an aircraft after the plane arrives and are discovered by the cleaning crew or the airline personnel long after all the other ambulatory passengers have deplaned which is obviously not an acceptable situation. The third category that comes to mind would be leaving a disabled traveling unattended in a wheelchair for more than 30 minutes. We hear from folks who allege they have been assisted to a gate area for taking flight but then removing from the carrier's wheelchair and left unattended in a stationary chair in the gate area for an extended period of time. Our rules prohibit leaving someone unattended unless they are independently mobile for more than 30 minutes. The fourth category is failure to respond dispositive written response to the complainant. Since I have a fairly good knowledge of the rule, know that the airlines are required to send detailed responses and therefore we scrutinize whether we feel the response is in fact thorough and addresses all the issues that the passenger has raised. Initially when we put the rule out years ago, some of the airline replies have been vague apologies that didn't necessarily address all the specifics of the a particular incident or advise the passenger of the recourse to contact the department which is also a requirement of our rule. But within the last several years, the carrier replies have shown a marked improvement in the quality of the response to the disabled complaint antes which is really good. In addition, our data seems to suggest that folks with disabilities who are entitled to special seating accommodations as I said earlier, maybe a bulkhead seat if they have a service animals,

those kind of folks occasionally experience difficulties in obtaining a particular seating accommodation in some instances. A lot of it has to do with the fact that load factors since 9/11 have greatly increase and as anybody who has traveled recently knows sometimes you can't find any kind of seat let alone one that may be suits your needs as a disabled individual. Having said that, there are specific categories of folks who are entitled to seating accommodations in most instances. We also receive a significant number of inquiries from consumers who have questions about the cost and availability of inflight medical oxygen and I'll touch on that issue in just a minute when I go over some of our rule make activity. In addition to the potential violations I mentioned briefly, we also receive complaints that allege for lack of a better phrase, bad attitudes or courtesy or sensitivity by airline employees or their contractors when they are interacting with individuals with disabilities. And it's often this type of alleged insensitive treatment and not a violation of a regulation itself which results this complaints. I've been talking for awhile now. So to steal a line from Don Henry of the Eagles, with you with me so far, Tajauna. That's out of life in the fast line as you know.

TAJAUNA: Yes, I am still with you.

MIKE: Just nod your head, Tajauna. Thank you. Well now that I've talked a little bit about complaint trends and how we handle complaints internally here at DOT I thought I'd do a quick overview and provide some details on what my office does or has been doing in the last couple of years specifically in the disability area and then attempt to answer any questions that folks might have. I'll try to focus my comments this three basic areas, number one, investigations and enforcement activities, number two would be rule-making activity, and three is outreach and public education. With regard to investigations and enforcement as I mentioned preliminarily, I do work in an enforcement office at DOT and although our basic philosophy in my office is to work informally with airlines to resolve issues in a cooperative manner which seems to

work great, there are occasionally times when DOT that is to take enforcement against airlines either because we don't see eye to eye on what airlines should provide or there seem to be repeat issues or patterns or practice of violations which sometimes result in me having to involve the attorneys with whom I work across the hall in an enforcement context. For example, in I believe it was calendar year 2003 and 2004, we concluded a large number of enforcement investigations which resulted in the slue answer of what we called consent orders which assessed significant civil penalties against airlines for violation very our disability rule. Those that I'm referring to, most of the ones in 2003 and 2004 involved either alleged failure to provide adequate wheelchair emplaning and deplaning and connecting help as well as a parent violations of the in cabin wheelchair stowage provisions of our rule. I believe we assessed civil penalties somewhere in the neighborhood almost \$6 million in 2003 and I think 1.2 million or so in calendar year 2004 for that kind of complaint that we were investigating. More recently, we've issued three consent orders in October 2005. One against a major U.S. carrier assessing a civil penalty for inappropriately denying boarding to a passenger because she was not traveling with an attendant. And we also assessed civil penalties against two other U.S. carriers for not having in cabin stowage facilities. It's been our policy within the last couple of years to allow carriers to what we call offset a large portion of these civil penalties which I think is a really kind of neat program. Rather than sending a check to Uncle Sam where it goes to the federal treasury, a lot of it is offset for programs and activities that will directly benefit consumers with disabilities. This money, just so I'm clear, has to be spent on programs or activities that go over and beyond the minimum requirements in our disability rule. One major carrier was allowed to offset the penalty toward oxygen concentrators. Another carrier was allowed some offsets for instituting what they called a quality assurance program in which they allowed folks to fly on their aircraft and report back to them as to the quality of the service the

carrier was providing to folks with disabilities. Another carrier was allowed a significant amount of money for an offset to beef up its website and provide a lot more information about DOT, my office, our disability rules and the availability of a toll free hotline that we also have available to the public I'll mention in just a minute. There are some fairly innovative opportunities for airlines to provide -- put their money toward a program activity that will directly benefit disabled travelers rather than sending a check to the federal treasury where it will be misspent by Congress. I hope we can delete that last sentence so I will have a job tomorrow. This is a time delayed presentation, right?

TAJAUNA: Yeah, we'll have to talk to the captioner about deleting that last sentence.

MIKE: In another kind of recent and pretty innovative activity we've been involved in recently in the summer of 2005, DOT announced an aircraft inspection program in conjunction with the FAA on compliance with those aircraft accessibility requirements that I'd outlined earlier. Things like having movable aisle arm rests, stowage space for folding wheelchairs, accessible bathrooms for disabled individuals and having incabin aisle chairs to get folks from an aircraft seat to the bathroom. The inspections are currently ongoing by the FAA and we're in the process now of reviewing the results of those inspections of the aircraft and contacting carriers where needed to discuss any deficiencies that the inspectors may have found. Also of note in the enforcement investigation area is the fact that several investigations have been initiated involving foreign airlines and what we feel are possibly inappropriate policies in requiring attendants or medical certificates as a condition of carriage for passengers with disabilities. Those investigations are ongoing and could result in the issuance of consent orders as I mentioned in the assessment of civil penalties. Similar to the ones I had mentioned about U.S. carriers and in fact in August 7th of 2006, just about a month or so ago, the department announced the enforcement office where I worked, we reached a settlement with

one large foreign airline and assessed a 50,000-dollar civil penalty for what we think was the carrier's inappropriate requirement that several individuals who travel with a wheelchair could not travel without an attendant. So we tested that civil penalty against that foreign entity. It's the first time that the Air Carrier Access Act enforcement settlement involved a foreign carrier for treatment of a person with a disability since Air 21 which again as you now know, Tajauna was the law that extended the active provisions of the Air Carrier Access Act to cover foreign airlines. Since that was signed into law on 575th, 2000, that was the first consent order that directly involved the Air Carrier Access Act violations by a foreign airline. And under the terms of that particular settlement of the 50,000-dollar assessed civil penalty, I believe it's \$45,000 of that is going to be put towards one of these offsets I mentioned which is going to be used towards enhanced training of airport personnel regarding the proper standards for accepting folks with mobility related disabilities on flights from the U.S. into the UK. Finally, as it relates to enforcement investigations, we made a significant progress toward reducing the number of pending disability complaints we've received at DOT. I apologize to any of you out there who may be listening who have filed a written complaint with my office although by now I'm sure you received an acknowledgment letter. You may not have received that final concluding letter. We're working hard to a point where we're getting final responses out to folks in a much more timely fashion thanks to a fairly recent hiring of enforcement attorneys and analysts such as myself. To those waiting for a reply, it should be coming to you soon. We beg your pashes evens a little longer on that. It takes awhile to review these. They are not something we can kick around and turn over in a week. With regard to the second area I thought I would talk about real briefly is rule-making that I happen to be involved in myself as well. Within the last year or two, we focused -- you might say more energy toward rule-making than enforcement and I'll mention four such disability rule-making currently underway. I thought I'd go quickly

over how the process works. DOT issues what we call a notice of proposed rule-making or N.P. R.M. Which now we have CRO, BLT and N.P.R.M, is that right, Tajauna?

TAJAUNA: Mike, while I have you, if I could get you to slow down a bit. Thank you.

MIKE: Sorry again to the transcriber. I'll try to think more slowly. I should have had a beer or two before we started. In any event --

TAJAUNA: I'm thinking instead there was some caffeine.

MIKE: I didn't even have my caffeine this morning. You know, some of us people don't sit around drinking coffee and reading Sports Illustrated. DOT has issued a notice of proposed rule or N.P.R.M. which as the name suggests is in fact a proposed change either to the current regulation or might be a new requirement altogether. After we issue the N.P.R.M, any interested parties, a consumer, disability rights organization, an airline, et cetera, have a set period of time in which to submit written comments to the proposal and after the comment period is closed, DOT then spends a considerable amount of time thoroughly reviewing the comments and we incorporate those comments to the extent possible before we issue a final rule. And I want to emphasize here that with one exception the proposed rules I'm going to get into real quickly, they are in that draft or proposal stage so that any final rule that might be issued could differ significantly from what it's been proposed in the draft rules themselves. So just without any further ado, a couple of quick rule-makings we're working on right now in the disability area, the most important one in the sense that comes to mind is what I refer to as the Big Kahuna rule-making which will extend the applicability of our disability rule to cover foreign airlines as I mentioned, when Air 21 was passed back on April 5th, 2000, it extended the applicability of the Air Carrier Access Act itself to cover foreign airlines. But the act is really just a very brief law that says to airlines thou shalt not discriminate against disabled folks. Then there is 15 page or so implementing regulation. The law itself, the act applies to foreign and U.S. carriers, but the

implementing rule does not yet -- although we have asked -- we use the underlying rule Part 382 as guidance to determine whether a foreign carrier is or is not in compliance with the intent of the Air Carrier Access Act. So the big rule-making we're working on is the one that will extend the applicability of Part 382 to cover both U.S. and foreign airlines. Also of some significance, my office has been working very closely with the federal aviation administration or FAA on the issuance of what's called a special federal aviation regular. There is another one for you, on portable oxygen concentrators or P.O.C.'s. That was issued in July of 2005. It's an enabling rule. I'll repeat that. It's an enabling rule which basically means the carriers after they conduct appropriate tests on whether a given portable oxygen concentrate does or doesn't affect the electromagnetic -- whether it has any electromagnetic interference, once they've done the testing to make sure that a given portable oxygen concentrate is safe to use, carriers may allow the use of them, but they are not required to allow their use, and I'll talk about our corollary rule in just a second which will require airlines to permit the use of approved P.O.C.'s in just a second here. When the FAA rule was first published back in July of 2005, the FAA had approved the use in flight of two portable oxygen concentrators. They were approved for use in flight by the FAA. However, just yesterday, the FAA published an amendment to that rule which allows for the use of three more portable oxygen concentrators under certain conditions. For those who are interested, those newly approved portable oxygen concentrators are (so listed) it's also my understanding that the FAA is drafting a guidance document in Q. and A. format at the request of many airlines and consumers which will provide further information on the appropriate use of a portable oxygen concentrate in flight. Another draft rule which is still in the review process here in my office is what I refer to as a corollary rule to the FAA's portable oxygen concentrator rule would require airlines to provide oxygen either using compressed oxygen canisters or portable oxygen concentrators and testing other

respiratory devices. There are four devices the airlines on paper will have to test if the rule goes final as it is published right now, airlines will have to test ventilators, respirators, CPAP machines which as most of you know stands for positive air pressure machines. So that rule on paper right now will require airlines to provide at no cost to the traveling public oxygen during flight, as well as to test four specific types of respiratory devices that are owned by consumers. That comment period has closed, so we're now reviewing something like 1900 comments I believe in that particular docket. By way of background, I probably should have mentioned this initially, P.O.C.'s are relatively new technology that differs from the traditionally provided compressed oxygen cylinders you may have seen on aircraft. I'm not an engineer, but it's my understanding that a portable oxygen concentrator essentially works by filtering out nitrogen from the ambient air within the aircraft and then providing the users of the P.O.C. with oxygen that's at roughly a 90 percent concentration level. It takes air in the cabin, filters it and then what you're breathing through a tube is 90 percent pure oxygen which is kind of cool. And again, briefly, our corollary rule as drafted will require all U.S. and foreign airlines that operates flights either within or to and from the U.S. with an aircraft with more than 60 passenger seats to provide oxygen at no charge and to test those four devices that I just went over. Carriers are going to have 90 days from the receipt of a given device from an individual or a manufacturer to complete the testing to make sure it does not negatively affect the controls of the plane. We don't want a plane heading to Cleveland to end up in a foreign country so we want them to do whatever testing is needed to make sure their use will not have a negative impact on steering the aircraft or have any other negative safety results. As a said, I think we received something like 1900 comments on that particular rule alone. One last comment on draft rules, we also issued a rule back in February of 2006, again, it's an N. P. R. M. or proposed rule that's going to require additional accommodations for individuals who are either

deaf, hard of hearing or both deaf and blind. That again will apply to both U.S. and foreign airlines that operate into and out of the U.S. and to the aircraft that serve the markets and to the airport facilities that relocated in the U.S. which are owned or leased or controlled by the airline. That comment period is also closed. Among the other issues that are addressed in that particular rule-making is captioning of safety and informational videos on the aircraft itself. The accessibility of airlines' telephone systems and their reservation systems. For example the service and response time for a TTY phone line. The accessibility of airport facilities within like a gate area for example whether we should or shouldn't require captioning of the T. V. sets that you'll see when you are sitting waiting for your flight, or any other audiovisual device that might be in the airport. It also addresses the training of carrier personnel and suggests that there might be a better communication with individuals who have visual and or auditory impairments. Our intention -- I've mentioned just now four different rule-makings, our intention as we're keep all these balls in the air is to eventually after reviewing all the comments by sometime I believe in early 2007 is to publish one new Part 382 which will apply to both U.S. and foreign carriers and which will incorporate all three of the draft rule-makings that I just mentioned into one big final rule. It's possible we might complete our review of the oxygen rule-making first and issue that as an amendment to the current rule, but I believe our ultimate goal is to publish one new regulation that applies to both U.S. and foreign airlines and which will incorporate all three draft rule-makings into one final document. Briefly, real quickly to go over some outreach and public assistance activities, the third element of what my office does, in addition to offering a large number of educational documents on our website, things like our new horizons booklet for the air travelers with a disability which we think explains passengers rights in the context of traveling if you've got a disability. We have various one page fact sheets on disability issues. We have a complaint form if you rarely hopeful any you

want to file a complaint. There is a complaint form on our website. We also have a free fax -- toll free fax on demand system where you can get any of our publications for free via the fax system. For those who might be interested in Fe want to go on our fax on demand system, I'll give that you number, 1-800-454-3114. Our website if you want to go on our website to look at any of the information we've got on there, which has a wealth of information for folks, I suggest you look at it if you haven't, that website I believe is <http://airconsumer.ost.dot.gov>. So that's our website. In addition, you may have heard fairly recently we issued two other documents in conjunction with an outside contracting company called the Keybridge Foundation. It's a private contractor we put together what we call a technical systems manual and a model training program. The technical assistance manual is intended to explain in plain English the gist of Part 382 and the responsibilities of both airlines and the rights of consumers under the Air Carrier Access Act. The model training program is just a suggested supplement to carriers' existing training programs. And they are posted on the website which I understand is also section 508 compliant for those who haven't looked at it. Which means us can read it whether you are blind or not. I alluded to earlier the fact that we issued an amendment that requires foreign airlines and U.S. carriers to submit complaint data to DOT. We as I said issued our first report to Congress summarizing that data last year. We're working on our second report. As is essentially true for the complaints that consumers filed directly with my office, approximately half of the complaints sent directly to airlines seem to involve alleged failure to provide adequate assistance to folks who request wheelchair assistance. That's also available on our website who want to see the summaries. We're also currently finalizing -- this is a fairly significant initiative, we're finalizing an industry guidance document on the carriage of service animals in the cabin on flights into Great Britain. As most folks know in most instances if you fly into Great Britain with an animal, unless you go

through certain procedures, there is the possibility your animal will be sent to quarantine, but this document explains the steps necessary to transport a service animal legally into Great Britain without having to have the animal quarantined. The three basic goals of the document when we issue it soon, I hope, is number one to inform individuals with disabilities on the proper procedures needed to comply with Great Britain's what they call their pet travel scheme, for example, ensuring the service animal has obtained proper rabies and other vaccinations, documents the service animal has been microchipped and those kind of technical things that are required by the government. The second goal of the document is to inform both U.S. and foreign airlines on the proper procedures for the submitting and gaining approval of the procedures for accepting a service animal in the cabin. That's monitored by what they call DEFRA, the Department of Environmental Food and Rural Affairs. That's an English entity that oversees this issue. And the third basic goal of that particular document is going to notify both U.S. and foreign airlines that operates flights between the U.S. and Great Britain that any fare to obtain approval from British authorities to transport a service animal in the cabin in compliance with applicable law would be considered by DOT to be a violation of the Air Carrier Access Act, which could subject the carrier to enforcement action by the Department of Transportation if in fact that were the case. And last but certainly not least, as it relates to outreach and public education, and I'll be happy to try to take some questions, we probably have some of you might have heard back on August 5th, of 2002, the department instituted a toll free hotline so we celebrated our fourth anniversary of this toll free disability hotline system. The intent of the hotline system is for individuals with disabilities who are traveling by air, obviously, so they have a recourse to contact us by phone so we can provide them information and realtime assistance if they are having an issue involving an airline in the airport. The phone numbers for people who have not heard of the hotline and there aren't a whole lot of

people that have heard of it, the phone numbers is a toll free disability hotline is for the voice is 1-800-778-4838. Again, if you do it by the voice system, it's 1-800-778-4838 and if you have to rely on a TTY, we have that service, the same hours, had is 2-800-455-9880. 1-800-455-9880. The hotline currently operates from 7:00 a.m. until 11:00 p.m, 365 days a year except for on Elvis' birthday -- I'm pausing here for the E-mail laughter to come through -- I'm just kidding. It's open 365 days a year even on Elvis' birthday. I wanted to see if you're still listening, but you're not laughing.

TAJAUNA: I'm laughing on the inside.

MIKE: Good.

TAJAUNA: Those hours, are they central, eastern?

MIKE: It's eastern time. Again, right now the hours are 7:00 a.m. to 11:00 p.m. eastern time. Having said that, and this is significant, on October the 1st, we're changing the hours. They are going to be changed to operate from 7:00 a.m. to 5:00 p.m. eastern time Monday through Friday except for federal holidays. So we will no longer be accepting calls, a real person like myself, will not be accepting calls any longer from 5 to 11:00 p.m. nor will we be available on the weekends. We will be available ten hours a day, Monday through Friday, except holidays. We think this is a tremendous service. We on a daily basis get contact from folks who need help explaining what their rights are or in some cases actually contacting the airline to work through an issue if someone is getting ready to board a plane and they are needing something, we can interact and have contacts with all the carriers and in a very timely manner most of the times we can take care of these things in a realtime basis so people don't have to send mail to DOT to me. In any event, I know some of this is very dry. I guess in conclusion, I'd really like to thank Tajauna and all those at the disability resource project in Houston, Texas for letting me get involved in the web case. As I hope you've been able to gather from my remarks, DOT is very strongly committed to ensuring airlines' compliance with the Air Carrier Access Act and protecting the civil rights of

passengers with disabilities so on that concluding note, I'd be happy to try to answer any questions that you, Tajauna, or the listeners might have about anything I've said or anything I didn't cover.

TAJAUNA: Okay. Well, we have quite a few questions. So I tried to put them in some sort of order. Some of the questions, the topics you have touched on, but I'm going to go ahead and ask some of them so that because they are more specific. So I'm going to start off, the first one is the oxygen issue and the question says during hurricane Rita when people used oxygen were taken to a staging area to evacuate, they were all put on ground transportation rather than planes because of the oxygen use. This is still part of a local government plan. Should disaster plans in general, specifically address that oxygen should be allowed on all forms of evacuation transportation?

MIKE: Wow. I hate to be bureaucratic, but I can't really comment on behalf of the department about what local entities should do in the context of ground transportation. I'm really more of an expert on what airlines should or shouldn't do. I'm not aware of any specific prohibition about carrying oxygen on the ground although obviously there were some severe problems in the context of the evacuation after the hurricane. It's my understanding that there were some oxygen canisters or cylinders that started a fire which caused several fatalities on one of those buses. So I had on rather defer whether they should R shouldn't, just speaking for my personally, that's a great idea to coordinate with the appropriate authorities about what they should R shouldn't do in the context of carrying because oxygen is in fact a hazardous materials if it's administered in the form of a compressed oxygen cylinders. Hazardous materials are named that because they can pose safety concerns. So obviously I would suggest that they coordinate with the folks in their local hazmat offices and I'd be happy if they want to send me an E-mail after the fact to get in touch with DOT's hazardous materials office to discuss that further.

TAJAUNA: at the same time, individuals were instead of put on airplanes because they were using oxygen, they were instead put on ground transportation, and so with that, now if they are being evacuated, has the oxygen use -- they are now being evacuated, can they now get on airplanes with their oxygen vs having to take ground transportation?

MIKE: Well, I'll put it this way, when the FAA issued their rule which as I said in an enabling rule, that allowed U.S. carriers to allow folks to get on with five -- well, initially two, now five FAA tested and approved portable oxygen concentrators. So right now, the FAA has basically said they have tested to their satisfaction that five different portable oxygen concentrator devices do not pose a severe risk from the perspective of -- well, any kind of safety risk, however, they still have to undergo E. M. I. or electromagnetic interference testing to make sure there is inform problems in that area. Once those tests are all done, they are free to use those on the plane. That is the FAA says it's not a safety issue, but the rule doesn't mandate that carriers use them. That's why DOT and the office that I work issued a corollary rule that will in fact mandate the testing and use of any P.O.C. device that has been deemed safe. So, in other words, right now, carriers are free to allow a personal P.O.C. on a plane. They are also free not to allow it on the plane if they don't choose to do it. And the reason is we have not completed our draft rule. Once our draft rule goes final, if it goes final as it is written, our rule will in fact mandate that a consumer will be able to go and provided they using a device that's been tested by the FAA and deemed to be safe and it doesn't pose any concerns as far as enter fear Wednesday with the steering of the plane, our rule will main date that those folks will be able to use them. Right now carriers can choose to allow their use or choose not to. And six months from now that could be very different.

TAJAUNA: Thank you for the clarification. The next question states I was discriminated by a foreign airline who stated that as a person with a disability I cannot fly by myself because by

international safety laws, they require to make sure customers with disabilities need to have someone to a system in case of emergencies. Does such a rule exist?

MIKE: I'm not sure which foreign entity you're referring, but I know that some international air transport association guidelines do address that issue. I don't have it in front of me the guidelines which I understand are some what more stringent than the regulation that I -- the office where I works that monitors compliance with. Briefly, the passenger is referring to something about a mobility difficulty, our rule essentially says if an individual can assist in their evacuation, they should not be required to fly with an attendant. It's my understanding that the guidelines and some foreign carriers have much more restrictive rules that for example might say not only do you have to go with an assistant in an evacuation, you also have to get to the bathroom without assistance. That would be prohibited with a U.S. carrier. A U.S. carrier cannot require someone to have an the end ant simply because of a concern that they need assistance getting to the bathroom. Our standard as I said is if you can assist in your evacuation, you would not be required to have an attendant. In putting it in terms you can understand, for example, if you're nonambulatory, but a paraplegic, you've probably got use of your upper body. In most cases, most pair a pledgee lx would not be required to have an attendant in my view because they can use their upper body to assist getting -- they can physically assist getting to the exit. Someone who might be characterized as a quadriplegic could argue, depending on the level of their ability, could be required to have an attendant because they are not capable of assisting in their evacuation. But this touches on the fact that this is one of the reasons we're going through this rule-making because although we have a rule now that applies to U.S. carriers and we look at it as guidance as to what foreign carriers can do, the real provisions of the rule I just looked at doesn't apply to the foreign airlines yet. It will very soon. We will have run rule

applying to all carriers, both U.S. and foreign and unless there is a specific conflict between the final rule we issue and the regulation or law of a foreign government, in most cases, at least on paper, the foreign airlines will have to comply with our rule unless there is a direct conflict of law between the foreign government and our rule.

TAJAUNA: Okay. All right, whenever you were talking about the complaint resolution official, the CRO, are all airlines required to have a complaint resolution official and does that include foreign airlines?

MIKE: That's a good question. The quick answer is that all U.S. carriers that provide scheduled service must provide a CRO and all do have a CRO. I speak with them frequently. The specific provisions of the rule requiring a CRO, again, not to belabor it, those rules don't specifically apply to the foreign airlines, but in real life, most foreign carriers have what is tantamount to a CRO. They have all in the context of all the legwork that we did in preparation for turning on our toll free disability hotline, in addition to getting a contact that I can personally get through to immediately with all the U.S. carriers, who is a designated CRO, we went to most of the foreign carriers that fly into and out of the U.S. they voluntarily gave us the name and number of contact people, although they may not be designated CROs, they are familiar with our rule and the intent of the Air Carrier Access Act and we can get in touch with them almost immediately and they are very conversant with the way we think things should go and we can resolve things very quickly. So the quick answer is the requirement to have a CRO specifically applies to only U.S. carriers providing scheduled service, but in the real world, because we are proposing that even foreign carriers in this draft rule have them, the handwriting is sort of on the wall so to speak. If the rule goes out in the final form as drafted, it will require form airlines to have CROs as well, but they already have in place something similar to that. If you have a problem with a foreign airline, I suggest you ask to speak to one who knows about DOT's

disability rule. If you think you're getting rushed, you can call the 800 number I gave out earlier. You can call me at that number and I'll work through the issue with you and I'll call the airline if I feel it's appropriate.

TAJAUNA: The next question, I have a disability similar to cerebral palsy and one of the problems I have is using the bathroom. Usually I just use the rest room before going and then hold it until I get off. I'm wondering what do you mean when you say accessible bathroom and how do you find out which planes have one?

MIKE: That's a great question. And I wish I knew the answer to it. No, I'm kidding. I know the answer to it. Yeah, when we say accessible lav, it's one that permits a person with a disability to enter the bathroom, maneuver within the bathroom as necessary to use all the facilities and exit it by means of the airline's on board wheelchair and the lav has to have certain accessibility features like door locks, accessible call buttons, grab bars and faucets and other controls, dispensers that are usable by folks with disabilities. The basic intent is that you should be able to take the wheelchair on the plane that the carrier provides, what I will call an aisle chair, be transferred from your seat to the aisle chair, assisted down the main aisle to the lav, the carriers are not required to assist you within the lav, but you should be able to enter the lav on your own in the aisle chair. Use the bathroom and then exit still in the aisle chair. It has to be that big, but again, the requirement to have that accessible lav is only on twin aisle aircraft of a certain vintage. We have a separate provision in the rule, I probably should have mentioned, that requires on request that carriers give you accurate information about the extent to which they can or cannot accommodate any kind of an accessibility issue. So for example in your context if you were taking a trip you can call in advance and say, hey, I want to know before I give my money I need to use the bathroom, I am not ambulatory, if that's the case, forgive me if I'm mischaracterizing your condition, and just ask them do you have an

accessible bathroom and they are required under our rule to tell you. The same would hold true for anything, if you want to stow a walker, a cane, a crutch, you name it, we have ability in the provision that on request once you give them some level of specificity about what you're asking, they are required to give you accurate information about the aircraft that is scheduled to be in the market. Occasionally, as you can imagine, because they are just machines, planes break and they sometimes will swap aircraft equipment out. But as long as the information at the time they give it to you is accurate, they would be in compliance with our rule. I hope that answered your question.

TAJAUNA: Since you mentioned -- I thought maybe I heard you mention walker, you might have said cane, the next question says that each time I fly, I have a difficult time convincing the flight attendant that my walker folds and must be stored in the cabin in the closet. Am I mistaken?

MIKE: No, I wouldn't say you're mistaken that they give you a problem about that. No, I'm being a little facetious. We have a requirement that they stow any device that can be stowed in compliance with FAA safety regulations. For example, if you have a walker that folds and will in fact for example fit in the overhead and since I cannot imagine that a walker would exceed the weight bearing capacity of the overhead, if it goes in the overhead, they would be required to put it there. If it goes in the closet, they argue would be required to put it there but just so I'm clear, there is a specific provision that mandates that they give priority stowage to passengers folding wheelchairs in the on board closets. So unless there is a weird scenario where you happen to be taking a flight where either one or more individuals were traveling with folding wheelchairs and putting those in the closet, and that's the only place big enough to put your Walker, I can't imagine there would be a problem accommodating a Walker in the aircraft cabin. You know, if you don't already have a copy, you can look on our website, Part 382 of our regulation. If you want to jot down section

382, I'm pretty sure it's section 382.481 of our rule talks about priority stowage space for assistive devices in the cabin. So you might want to printout a copy of 382 and carry it in your back pocket and you might want to whip it out and educate the flight attendant. I'm not saying if the thing doesn't fit you can't get ten pounds of potatoes in a five pound bag, assuming it fits it should not be an issue and maybe you're just dealing with a flight attendant who wasn't super familiar with our regulation.

TAJAUNA: on that, one of my questions, do the airline personnel, do they receive disability sensitivity training?

MIKE: Do the airline personnel?

TAJAUNA: Yes.

MIKE: Our regulation requires that public contact employees receive training as appropriate to the duties, which is somewhat vague, you might say. We left it almost deliberately vague because we and the carriers to have the opportunity to tail the training according to what the person does. It doesn't specify it has to be sensitivity training per se, it's more on what they absolutely have to do under the terms and conditions of Part 382. Having said that, I have been to most of the U.S. carriers' training sessions, almost all of them do touch on sensitivity. That is not only the nuts and bolts of what they have to provide for folks with disabilities, but the fact that it should be done in a polite and sincere representative manner. So most of them even though the rule doesn't say you have to have sensitivity training, they just out of common sense because they want to get your business back and want to do the right thing, do in fact in real life in the training touch on sensitivity and the appropriate way to treat folks with disabilities so it's done in a dignified manner.

TAJAUNA: Okay, the next area goes into service animals, and I actually have three questions on service animals. The first one asks would you speak about relieve areas for service animals, any guidance on the number of areas and type of ground cover?

MIKE: Okay. I'm sorry, that's the same question three times or is that the first of three?

TAJAUNA: That's the first of the three.

MIKE: Our rule doesn't specifically address relief areas. But having said that, because we've been working for the last couple of years on this initiative to extend the rule to cover foreign airlines, and we obviously realized that folks if we have our way will be getting better access to trips all over the world, that issue has been brought up in the context of that rule-making. We appended to the proposed rule a previously existing guidance document on service animals and asked the public to give us comment on that very issue. So we're -- I'm not at liberty to say where we might be leaning, but we have raised the issue of relief areas for service animals. You might want to go on to docket for that rule-making and see the kind of comments that have been suggested. We've been wrestling with things like should there be a certain length of a flight, ten hours or 12 hours, incumbent on the airline to have a relief area for an animal. It's not an easy issue because in many cases the airlines themselves don't have control over the airport facility. So they sometimes if we got into trying to regulate mandating a relief area, there may be some sort of a shared responsibility between the airline and the airport as to how that would work, but we are aware of that as an issue. We've got a heck of a lot of comments from the public about service animals and a whole bunch of issues about whether there should be relief areas. What about relief areas not only in airports, but on airplanes, so we're wrestling with that. I don't know where the rule will come out, but in the preamble to the final rule we'll probably be addressing relief areas. It's something on our radar screen and I believe we'll be discussing in the final rule when that comes out.

TAJAUNA: Sometime ago the DOT published a new guidance concerning service animals. Many airlines have read this guidance and concluded that a service dog must fit into the space in front of the passenger seat and within the width of that seat. With a typical

coach seat being 16-inch wide, it is the rare service dog that is a guide dog -- hold on one second. With a typical coach seat being 16-inch wide, it is the rare service dog that is a guide dog that is mobility assistance dog for people who use wheelchairs that can fit into a space that is approximately 16 by 16. Is this the correct interpretation of the guidance? If it is, then the DOT guidance has eliminated air travel for a large percentage of people with disabilities with service animals. If this is not the correct interpretation, then what is the DOT doing to let the airlines know that they have it wrong?

MIKE: Okay. I'd be happy to give you my comments on that. We have obviously raised this issue in the context of this rule making that I referred to. Just speaking for me, I think that perhaps some folks are misunderstanding the guidance. I don't know that the intent of the guidance, which does in fact say, a service animal should be able to fit essentially underneath the seat of the disabled individual, him or her self. Having said that, the preamble also goes on to say of that particular rule, that we don't necessarily want airlines to read that absolutely as an iron clad rule. That is if you happen to have an animal that might encroach a little bit on the foot area of the person next to you, I don't know that necessarily we would expect an airline to tell you that your animal is too big to be accommodated. In real life, I've been doing this a pretty long time, I have never had a complaint from a consumer in which an airline either refused transportation to a service animal or required a service animal owner to buy a second seat. They almost always in real life, if you have a very large animal, will work out a system. In fact, the rule itself mandates that if an animal will not fit in the area under your seat without posing a safety risk, the first thing they have to do is attempt to move you somewhere in the aircraft cabin where the animal can be accommodated. Having said that, there probably are going to be occasionally situations where people who for example have a german Shepherd, let's say and the animal can't physically curl up absolutely in your little 16-inch space, in real

life, I think airlines do the best they can to accommodate those folks, but I think it would have to be a pretty darn big -- I dwell disabled folks all day long, and it would have to be a fairly large animal on a fairly small plane where the airline said look you're encroaching so much on the foot area of the person next to you, they can't use their space. We have to deal with this. The way they would hopefully deal with it in compliance with the rule is attempt to move you somewhere where there is an additional seat, but the first thing we would have to do is move you to someplace else on the plane. If it's a full flight, and from fact the animal is so large that they literally can't sell the seat next to you, the rule does not require the airlines to sell an individual with a service animal two seats for the price of one. So if in fact they literally had to block off the seat next to you because your dog encroached significantly on the foot area of the passengers next to you, they'd be within their rights to provide some other options to, either taking a later flight that isn't as full, perhaps suggesting you buy a second seat. A third option which is completely untenable to most folks with disabilities would be to have the dog go in the belly of the plane. Please don't start screaming at me. I deal a lot with disabled folk as you can imagine. I know that's not an acceptable option. I wouldn't want to be separated from my service animal. Sorry for my long answer, but it's something on our agenda to address more specifically in the rule, but in real life, as I've said, I don't know of a situation where a dog was so big if we're talking the context of a dog, that they couldn't accommodated in one seat. So I hope that answers your question.

TAJAUNA: Okay, I'm going to leave service animals for a minute. We only have about close to ten minutes left and there are actually -- we have a lot of questions left, but I'm only going to be able to touch on a few and so I want to get a different categories in here. The next category is on listening devices and the question is are hard of hearing people allowed to bring wireless assistive listening

devices on the plane to use for communication with the flight attendant?

MIKE: Are they allowed to?

TAJAUNA: Yes, that's the question.

MIKE: My quick answer is yes, but having said that, it's my understanding that the FAA has a requirement that during take off and landing there may be situations in which if you've got for example a cell phone on, you may be required to remove that in order to understand safety briefings, for example. If in fact there happens to be a legitimate safety regulation, I can't put my finger right on it right now in the FAA rule book, but if there is a rule that requires all passengers not to be wearing head gear during certain phases of the flight, that arguably would apply to people who have no hearing problems as well as people who do. But if the basic question is can I use it during situations when they are not giving the safety briefing or whatnot, I don't see why there would be an issue with that.

TAJAUNA: Because that goes along with a second question where the individual says that the use of an augmentive alternative communication devices on the aircraft, as with most electronic devices, the regulations to have them turned off during taxiing, take off and landing. In the event of an emergency, however, as well as the need for regular communication, turning off the device renders most users unable to speak. What is the policy? I believe you just answered that.

MIKE: I can give them a more detailed response and give them some cites from both our rule and the FAA regulation about being able to give you a safety briefing and any kind of electronic device last to be turned off regardless of the nature of it. So my E-mail is Mike.Spollen@dot.gov. If you want to send that one on to me I might be able to respond after I do a little research and get back to them. If you're not in the states I can call you almost anywhere.

TAJAUNA: They're in the states. Thank you. Okay, the next section is on security. It asks can a person in a wheelchair be

required to disembark their wheelchair at the security check point and can they be required to remove their shoes?

MIKE: Yes and yes. I don't mean to be bureaucratic again, but as you probably know, security used to be handled by airlines themselves on a contract basis and then we established what's called the Transportation Security Administration which used to be a part of DOT and has been spun off into the Department of Homeland Security so the actual application of security directives at airports is actually handled by T.S.A. It's my understanding that if you're asked to get out of a wheelchair to go through the magnetic machine, and you cannot do that, they'll take you around. You will be subjected to security screening, but it will be via a wand and hopefully a discrete patdown. You have the right to ask for a private screening. If you are physically incapable of standing up and walking the two or three feet through the magnetic machine, tell the T.S.A. individual that. They'll take you around it. If you don't feel like being wanded and hand patted in the public, you can ask for a private screening and they'll give that to you. I don't have it right in front of me the T.S.A. directives, but not to be flippant, I think T.S.A. can tell you to do almost anything they want and if there is a legitimate concern about it, whether you are disabled or not, you are probably subject to it, but my recollection is that T.S.A. does not mandate that you take off shoes if you indicate to them that you're disabled or at a minimum will assist you in doing that. Again, you might want to just go on their website. They have an entire section on passengers with disabilities and special needs and in there they do address shoes I believe. If you can't find it, shoot me an E-mail and I'll search it with you and get back to you. So I hope that answer the question.

TAJAUNA: and then that also -- that website should also provide the answer to the individual who asked what has homeland security done post 9/11 regarding security issues and passengers using wheelchairs. It sounds like they can go to that same website and get all that information?

MIKE: They have a plethora of information and even more stringent requirements about not carrying certain amount of gels and creams and how that relates to people who need gels and creams and whatnot for medical prescription purposes, and if they don't have it, you can type in a question and although I can't vouch for their staffing, it's my understanding you can ask questions of T.S.A. via their -- through E-mail.

TAJAUNA: I have one last question -- actually a few questions that are left and I just want to let those who sent in questions, I want you to know that I will forward them to Mike. If he has a chance to answer them, I'm sure he will get back to you. If not, he can let me know and we will get back to you, but we did not get a chance to answer all of the questions so I'm going to ask one more that has three parts and then we'll close it from there.

MIKE: Okay.

TAJAUNA: the last one states, if a person with a disability traveling requires a personal care attendant, but the attendant have to pay for an additional seat? If a person with a disability traveling does not have an attendant with them, and needed to use the rest room facilities, would the flight attendants a system, not only in transporting them to the rest room, but with hygiene, self-care needs and I think you already answered part of that question.

MIKE: I think I'm hearing two questions here.

TAJAUNA: I'll let you answer that one and then I have one last question after that one.

MIKE: I'm trying to remember the first part of the question. One of the parts was would they help you twin bathroom and the quick answer to that is no. They have to assist you in transferring to an aisle chair and push you up to the door of the bathroom. They do not have to physically transfer you to be indelicate from the aisle chair to the commode. That would be incumbent upon you. With regard to the first issue that just popped into my head, if in fact you want to travel with a personal care attendant, carriers are within

their rights to charge you for the seat for that personal care attendant.

TAJAUNA: Okay. And the last question is if a piece of equipment like a power wheelchair was damaged or lost, it was stated the airline would cover replacement costs in a timely manner. Can you be more specific to what that means?

MIKE: Okay. We remove the liability limits on domestic flights -- well, I say remove the limit -- carriers can no longer put a cap on the limit there. Is a cap of sorts in that they have to -- they have to use the original purchase value of the device as the amount of money that they would not go above. My point being if you had a 10,000-dollar wheelchair when you purchased it and you still got the receipt for that, and it costs \$6,000 to repair it under our rule, provided with all due respect it's a legitimate claim and they concede they damaged it they would pay you the full amount of it up to what you paid initially when you bought the device. When I say in a timely manner, usually carriers get on these things very quickly, kind of just to do the right thing. They kind of try to expedite requests for compensation in the context of damaged assistive devices, which could include even the cost -- the reimbursement cost for rental chairs and that kind of thing. Having said that, I can't give a specific number of days. Each carrier has its own internal goals as to how quick it takes to turn around a claim. It's my understanding provide you can get the device to a rental -- rather a repair shop that they will work with those repair shops in either sending a check directly to them or to you and you can give it to the repair shop, but I would think within a few weeks many claims are taken care of if they are not super complex or things that the carrier disputes that they were at fault. But if anybody feels as though they've got a claim pending with an airline that has been too long, whatever in your mind that is, whether et cetera it's a week or six weeks, you can call our 1-800 disability line and give us the details and we will call the airline and check the status of it and we'll get back to you. We do that all time where

folks feel as if they are not getting a response in a quickly enough manner and they'll call our hotline and we'll call the airline and say, hey, give us an update on it and we would be happy to did that for folks.

TAJAUNA: Thank you so much. Okay, that is all the time that we have for this web case. Again, Mike, thank you so very much. I'm extremely informative web case and you have oh provided some great information for everybody -- (Multiple Speakers).

TAJAUNA: I'm sorry, what?

MIKE: You got my E-mail address. Send any E-mails I didn't get to and we will respond as quickly as we can.

TAJAUNA: Thank you very much. Okay, so I hope all of you listening have learned from today's web case. Also note that this web case will be archived on ILRU's website, which you can find by visiting www.ilru.org. Also note that the websites and telephone numbers that our presenter has mentioned will be listed in that archive as well and/or you can contact us and we'll provide you with that information. I would like to acknowledge National Institute on Disability and Rehabilitation Research, NIDRR, who funds your host for today's program, the Disability Law Resource Project. I would also like to thank the in-house staff here at ILRU who without their efforts this web case would not be possible: They include Marj Gordon, Sharon Finney, Dawn Heinsohn, Vinh Nguyen, and Maria del Bosque. I would also like to thank the technical expertise provided by Rob Dickehuth and our realtime captioner, Marie Bryant. I encourage anyone with questions on the Americans with Disabilities Act to call the toll free number at 1-800-949-4232. Again, thank you for joining us and we hope you will join us again next Wednesday, September 20th, at 2:00 p.m. central standard time, to listen to the web case on fair housing, presented by Barbara Chandler with adaptive environments. For more about this web case or to see the schedule for all web cases, visit www.ilru.org. Again, thank you, Mike, and thank all of you for listening.

MIKE: Thanks, Tajauna, I appreciate it very much.

CMS Money Follows the Person Grant Solicitation, September 2006 Overview

Purpose:

- Rebalance LTC system so that individuals have a choice of where they receive services.
- Transition individuals from institutions who want to live in the community.
- Promote a strategic approach to developing a system that provides person-centered services, improvement in quality of life, and quality management.

Funding:

- \$1.75 billion appropriated thru 2011; \$250 million available for FY 2007.
- Enhanced FMAP (78%) for services for 12 months post transition. Grant staff and related costs matched at Administrative rate. Supplemental services at the regular service rate.
- No grant funding for project infrastructure.

Conditions:

- Proposals due November 1, 2006. Start-up January 1, 2008.
- 3-12 month planning period prior to implementation. Projects may be 2-5 years long.
- State must employ a full-time Project Director and participate in a national evaluation.
- Maintenance of effort requirement: state must continue community services for individuals beyond the 12 months of enhanced match.

Review criteria for applications:

1. Demonstration that the state is committed to the core purpose of the project: increasing the use of HCBS rather than institutional services. (20%)
2. Strength and appropriateness of the state's HCBS system, including plan for sustaining services beyond the 12 months of enhanced FMAP. (15%)
3. Quality of the plan for transitioning consumers. Priority given to plans targeting multiple populations and offering self-direction options. (15%)
4. Consumer role in project development and implementation and the tracking of consumer satisfaction. (10%)
5. Collaboration with the state housing finance agency. (5%)
6. Collaboration with institutional providers in planning and implementation. (5%)
7. Adequacy of project staffing and administration. Agency must hire a full-time project director; sufficient capacity to meet the reporting and evaluation requirements. (10%)
8. Strength of quality improvement mechanisms in HCBS. (10%)
9. Complete and sound financial plan for the project. (10%)

SUBSTITUTE FOR
HOUSE BILL NO. 5389

A bill to amend 1939 PA 280, entitled
"The social welfare act,"
(MCL 400.1 to 400.119b) by adding sections 109i and 109j.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 SEC. 109I. (1) THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY
2 HEALTH SHALL DESIGNATE AND MAINTAIN LOCALLY OR REGIONALLY BASED
3 SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE THAT SHALL SERVE
4 AS VISIBLE AND EFFECTIVE ACCESS POINTS FOR INDIVIDUALS SEEKING
5 LONG-TERM CARE AND THAT SHALL PROMOTE CONSUMER CHOICE AND QUALITY
6 IN LONG-TERM CARE OPTIONS.

7 (2) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MONITOR SINGLE
8 POINT OF ENTRY AGENCIES FOR LONG-TERM CARE TO ASSURE, AT A MINIMUM,
9 ALL OF THE FOLLOWING:

10 (A) THAT BIAS IN FUNCTIONAL AND FINANCIAL ELIGIBILITY

1 DETERMINATION OR ASSISTANCE AND THE PROMOTION OF SPECIFIC SERVICES
2 TO THE DETRIMENT OF CONSUMER CHOICE AND CONTROL DOES NOT OCCUR.

3 (B) THAT CONSUMER ASSESSMENTS AND SUPPORT PLANS ARE COMPLETED
4 IN A TIMELY, CONSISTENT, AND QUALITY MANNER THROUGH A PERSON-
5 CENTERED PLANNING PROCESS AND ADHERE TO OTHER CRITERIA ESTABLISHED
6 BY THIS SECTION AND THE DEPARTMENT OF COMMUNITY HEALTH.

7 (C) THE PROVISION OF QUALITY ASSISTANCE AND SUPPORTS.

8 (D) THAT QUALITY ASSISTANCE AND SUPPORTS ARE PROVIDED TO
9 APPLICANTS AND CONSUMERS IN A MANNER CONSISTENT WITH THEIR CULTURAL
10 NORMS, LANGUAGE OF PREFERENCE, AND MEANS OF COMMUNICATION.

11 (E) CONSUMER ACCESS TO AN INDEPENDENT CONSUMER ADVOCATE.

12 (F) THAT DATA AND OUTCOME MEASURES ARE BEING COLLECTED AND
13 REPORTED AS REQUIRED UNDER THIS ACT AND BY CONTRACT.

14 (G) THAT CONSUMERS ARE ABLE TO CHOOSE THEIR SUPPORTS
15 COORDINATOR.

16 (3) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ESTABLISH AND
17 PUBLICIZE A TOLL-FREE TELEPHONE NUMBER FOR AREAS OF THE STATE IN
18 WHICH A SINGLE POINT OF ENTRY AGENCY IS OPERATIONAL AS A MEANS OF
19 ACCESS.

20 (4) THE DEPARTMENT OF COMMUNITY HEALTH SHALL REQUIRE THAT
21 SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE PERFORM THE
22 FOLLOWING DUTIES AND RESPONSIBILITIES:

23 (A) PROVIDE CONSUMERS AND ANY OTHERS WITH UNBIASED INFORMATION
24 PROMOTING CONSUMER CHOICE FOR ALL LONG-TERM CARE OPTIONS, SERVICES,
25 AND SUPPORTS.

26 (B) FACILITATE MOVEMENT BETWEEN SUPPORTS, SERVICES, AND
27 SETTINGS IN A TIMELY MANNER THAT ASSURES CONSUMERS' INFORMED

1 CHOICE, HEALTH, AND WELFARE.

2 (C) ASSESS CONSUMERS' ELIGIBILITY FOR ALL MEDICAID LONG-TERM
3 CARE PROGRAMS UTILIZING A COMPREHENSIVE LEVEL OF CARE ASSESSMENT
4 APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.

5 (D) ASSIST CONSUMERS IN OBTAINING A FINANCIAL DETERMINATION OF
6 ELIGIBILITY FOR PUBLICLY FUNDED LONG-TERM CARE PROGRAMS.

7 (E) ASSIST CONSUMERS IN DEVELOPING THEIR LONG-TERM CARE
8 SUPPORT PLANS THROUGH A PERSON-CENTERED PLANNING PROCESS.

9 (F) AUTHORIZE ACCESS TO MEDICAID PROGRAMS FOR WHICH THE
10 CONSUMER IS ELIGIBLE AND THAT ARE IDENTIFIED IN THE CONSUMER'S
11 LONG-TERM CARE SUPPORTS PLAN. THE SINGLE POINT OF ENTRY AGENCY FOR
12 LONG-TERM CARE SHALL NOT REFUSE TO AUTHORIZE ACCESS TO MEDICAID
13 PROGRAMS FOR WHICH THE CONSUMER IS ELIGIBLE.

14 (G) UPON REQUEST OF A CONSUMER, HIS OR HER GUARDIAN, OR HIS OR
15 HER AUTHORIZED REPRESENTATIVE, FACILITATE NEEDED TRANSITION
16 SERVICES FOR CONSUMERS LIVING IN LONG-TERM CARE SETTINGS IF THOSE
17 CONSUMERS ARE ELIGIBLE FOR THOSE SERVICES ACCORDING TO A POLICY
18 BULLETIN APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.

19 (H) WORK WITH DESIGNATED REPRESENTATIVES OF ACUTE AND PRIMARY
20 CARE SETTINGS, FACILITY SETTINGS, AND COMMUNITY SETTINGS TO ASSURE
21 THAT CONSUMERS IN THOSE SETTINGS ARE PRESENTED WITH INFORMATION
22 REGARDING THE FULL ARRAY OF LONG-TERM CARE OPTIONS.

23 (I) REEVALUATE THE CONSUMER'S ELIGIBILITY AND NEED FOR LONG-
24 TERM CARE SERVICES UPON REQUEST OF THE CONSUMER, HIS OR HER
25 GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE OR ACCORDING TO
26 THE CONSUMER'S LONG-TERM CARE SUPPORT PLAN.

27 (J) EXCEPT AS OTHERWISE PROVIDED IN SUBDIVISIONS (K) AND (l),

1 PROVIDE THE FOLLOWING SERVICES WITHIN THE PRESCRIBED TIME FRAMES:

2 (i) PERFORM AN INITIAL EVALUATION FOR LONG-TERM CARE WITHIN 2
3 BUSINESS DAYS AFTER CONTACT BY THE CONSUMER, HIS OR HER GUARDIAN,
4 OR HIS OR HER AUTHORIZED REPRESENTATIVE.

5 (ii) DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT PLAN IN
6 PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS OR HER
7 GUARDIAN OR AUTHORIZED REPRESENTATIVE WITHIN 2 BUSINESS DAYS AFTER
8 THE CONSUMER IS FOUND TO BE ELIGIBLE FOR SERVICES.

9 (iii) COMPLETE A FINAL EVALUATION AND ASSESSMENT WITHIN 10
10 BUSINESS DAYS FROM INITIAL CONTACT WITH THE CONSUMER, HIS OR HER
11 GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE.

12 (K) FOR A CONSUMER WHO IS IN AN URGENT OR EMERGENT SITUATION,
13 WITHIN 24 HOURS AFTER CONTACT IS MADE BY THE CONSUMER, HIS OR HER
14 GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE, PERFORM AN
15 INITIAL EVALUATION AND DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT
16 PLAN. THE PRELIMINARY LONG-TERM CARE SUPPORT PLAN SHALL BE
17 DEVELOPED IN PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS
18 OR HER GUARDIAN OR AUTHORIZED REPRESENTATIVE.

19 (l) FOR A CONSUMER WHO RECEIVES NOTICE THAT WITHIN 72 HOURS HE
20 OR SHE WILL BE DISCHARGED FROM A HOSPITAL, WITHIN 24 HOURS AFTER
21 CONTACT IS MADE BY THE CONSUMER, HIS OR HER GUARDIAN, HIS OR HER
22 AUTHORIZED REPRESENTATIVE, OR THE HOSPITAL DISCHARGE PLANNER,
23 PERFORM AN INITIAL EVALUATION AND DEVELOP A PRELIMINARY LONG-TERM
24 CARE SUPPORT PLAN. THE PRELIMINARY LONG-TERM CARE SUPPORT PLAN
25 SHALL BE DEVELOPED IN PARTNERSHIP WITH THE CONSUMER AND, IF
26 APPLICABLE, HIS OR HER GUARDIAN, HIS OR HER AUTHORIZED
27 REPRESENTATIVE, OR THE HOSPITAL DISCHARGE PLANNER.

1 (M) INITIATE CONTACT WITH AND BE A RESOURCE TO HOSPITALS
2 WITHIN THE AREA SERVICED BY THE SINGLE POINT OF ENTRY AGENCIES FOR
3 LONG-TERM CARE.

4 (N) PROVIDE CONSUMERS WITH INFORMATION ON HOW TO CONTACT AN
5 INDEPENDENT CONSUMER ADVOCATE AND A DESCRIPTION OF THE ADVOCATE'S
6 MISSION. THIS INFORMATION SHALL BE PROVIDED IN A PUBLICATION
7 PREPARED BY THE DEPARTMENT OF COMMUNITY HEALTH IN CONSULTATION WITH
8 THESE ENTITIES. THIS INFORMATION SHALL ALSO BE POSTED IN THE OFFICE
9 OF A SINGLE POINT OF ENTRY AGENCY.

10 (O) COLLECT AND REPORT DATA AND OUTCOME MEASURES AS REQUIRED
11 BY THE DEPARTMENT OF COMMUNITY HEALTH, INCLUDING, BUT NOT LIMITED
12 TO, THE FOLLOWING DATA:

13 (i) THE NUMBER OF REFERRALS BY LEVEL OF CARE SETTING.

14 (ii) THE NUMBER OF CASES IN WHICH THE CARE SETTING CHOSEN BY
15 THE CONSUMER RESULTED IN COSTS EXCEEDING THE COSTS THAT WOULD HAVE
16 BEEN INCURRED HAD THE CONSUMER CHOSEN TO RECEIVE CARE IN A NURSING
17 HOME.

18 (iii) THE NUMBER OF CASES IN WHICH ADMISSION TO A LONG-TERM CARE
19 FACILITY WAS DENIED AND THE REASONS FOR DENIAL.

20 (iv) THE NUMBER OF CASES IN WHICH A MEMORANDUM OF UNDERSTANDING
21 WAS REQUIRED.

22 (v) THE RATES AND CAUSES OF HOSPITALIZATION.

23 (vi) THE RATES OF NURSING HOME ADMISSIONS.

24 (vii) THE NUMBER OF CONSUMERS TRANSITIONED OUT OF NURSING
25 HOMES.

26 (viii) THE AVERAGE TIME FRAME FOR CASE MANAGEMENT REVIEW.

27 (ix) THE TOTAL NUMBER OF CONTACTS AND CONSUMERS SERVED.

1 (x) THE DATA NECESSARY FOR THE COMPLETION OF THE COST-BENEFIT
2 ANALYSIS REQUIRED UNDER SUBSECTION (11).

3 (xi) THE NUMBER AND TYPES OF REFERRALS MADE.

4 (xii) THE NUMBER AND TYPES OF REFERRALS THAT WERE NOT ABLE TO
5 BE MADE AND THE REASONS WHY THE REFERRALS WERE NOT COMPLETED,
6 INCLUDING, BUT NOT LIMITED TO, CONSUMER CHOICE, SERVICES NOT
7 AVAILABLE, CONSUMER FUNCTIONAL OR FINANCIAL INELIGIBILITY, AND
8 FINANCIAL PROHIBITIONS.

9 (P) MAINTAIN CONSUMER CONTACT INFORMATION AND LONG-TERM CARE
10 SUPPORT PLANS IN A CONFIDENTIAL AND SECURE MANNER.

11 (Q) PROVIDE CONSUMERS WITH A COPY OF THEIR PRELIMINARY AND
12 FINAL LONG-TERM CARE SUPPORT PLANS AND ANY UPDATES TO THE LONG-TERM
13 CARE PLANS.

14 (5) THE DEPARTMENT OF COMMUNITY HEALTH, IN CONSULTATION WITH
15 THE OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES, THE MICHIGAN
16 LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION, THE
17 DEPARTMENT, AND THE OFFICE OF SERVICES TO THE AGING, SHALL
18 PROMULGATE RULES TO ESTABLISH CRITERIA FOR DESIGNATING LOCAL OR
19 REGIONAL SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE THAT
20 MEET ALL OF THE FOLLOWING CRITERIA:

21 (A) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
22 CARE DOES NOT PROVIDE DIRECT OR CONTRACTED MEDICAID SERVICES. FOR
23 THE PURPOSES OF THIS SECTION, THE SERVICES REQUIRED TO BE PROVIDED
24 UNDER SUBSECTION (4) ARE NOT CONSIDERED MEDICAID SERVICES.

25 (B) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
26 CARE IS FREE FROM ALL LEGAL AND FINANCIAL CONFLICTS OF INTEREST
27 WITH PROVIDERS OF MEDICAID SERVICES.

1 (C) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
2 CARE IS CAPABLE OF SERVING AS THE FOCAL POINT FOR ALL INDIVIDUALS,
3 REGARDLESS OF AGE, SEEKING INFORMATION ABOUT LONG-TERM CARE IN
4 THEIR REGION, INCLUDING INDIVIDUALS WHO WILL PAY PRIVATELY FOR
5 SERVICES.

6 (D) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
7 CARE IS CAPABLE OF PERFORMING REQUIRED CONSUMER DATA COLLECTION,
8 MANAGEMENT, AND REPORTING.

9 (E) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
10 CARE HAS QUALITY STANDARDS, IMPROVEMENT METHODS, AND PROCEDURES IN
11 PLACE THAT MEASURE CONSUMER SATISFACTION AND MONITOR CONSUMER
12 OUTCOMES.

13 (F) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
14 CARE HAS KNOWLEDGE OF THE FEDERAL AND STATE STATUTES AND
15 REGULATIONS GOVERNING LONG-TERM CARE SETTINGS.

16 (G) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
17 CARE MAINTAINS AN INTERNAL AND EXTERNAL APPEAL PROCESS THAT
18 PROVIDES FOR A REVIEW OF INDIVIDUAL DECISIONS.

19 (H) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM
20 CARE IS CAPABLE OF DELIVERING SINGLE POINT OF ENTRY SERVICES IN A
21 TIMELY MANNER ACCORDING TO STANDARDS ESTABLISHED BY THE DEPARTMENT
22 OF COMMUNITY HEALTH AND AS PRESCRIBED IN SUBSECTION (4).

23 (6) A SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE THAT
24 FAILS TO MEET THE CRITERIA DESCRIBED IN THIS SECTION OR OTHER
25 FISCAL AND PERFORMANCE STANDARDS PRESCRIBED BY CONTRACT AND
26 SUBSECTION (7) OR THAT INTENTIONALLY AND KNOWINGLY PRESENTS BIASED
27 INFORMATION THAT IS INTENDED TO STEER CONSUMER CHOICE TO PARTICULAR

1 LONG-TERM CARE SUPPORTS AND SERVICES IS SUBJECT TO DISCIPLINARY
2 ACTION BY THE DEPARTMENT OF COMMUNITY HEALTH. DISCIPLINARY ACTION
3 MAY INCLUDE, BUT IS NOT LIMITED TO, INCREASED MONITORING BY THE
4 DEPARTMENT OF COMMUNITY HEALTH, ADDITIONAL REPORTING, TERMINATION
5 AS A DESIGNATED SINGLE POINT OF ENTRY AGENCY BY THE DEPARTMENT OF
6 COMMUNITY HEALTH, OR ANY OTHER ACTION AS PROVIDED IN THE CONTRACT
7 FOR A SINGLE POINT OF ENTRY AGENCY.

8 (7) FISCAL AND PERFORMANCE STANDARDS FOR A SINGLE POINT OF
9 ENTRY AGENCY INCLUDE, BUT ARE NOT LIMITED TO, ALL OF THE FOLLOWING:

10 (A) MAINTAINING ADMINISTRATIVE COSTS THAT ARE REASONABLE, AS
11 DETERMINED BY THE DEPARTMENT OF COMMUNITY HEALTH, IN RELATION TO
12 SPENDING PER CLIENT.

13 (B) IDENTIFYING SAVINGS IN THE ANNUAL STATE MEDICAID BUDGET OR
14 LIMITS IN THE RATE OF GROWTH OF THE ANNUAL STATE MEDICAID BUDGET
15 ATTRIBUTABLE TO PROVIDING SERVICES UNDER SUBSECTION (4) TO
16 CONSUMERS IN NEED OF LONG-TERM CARE SERVICES AND SUPPORTS, TAKING
17 INTO CONSIDERATION MEDICAID CASELOAD AND APPROPRIATIONS.

18 (C) CONSUMER SATISFACTION WITH SERVICES PROVIDED UNDER
19 SUBSECTION (4).

20 (D) TIMELINESS OF DELIVERY OF SERVICES PROVIDED UNDER
21 SUBSECTION (4).

22 (E) QUALITY, ACCESSIBILITY, AND AVAILABILITY OF SERVICES
23 PROVIDED UNDER SUBSECTION (4).

24 (F) COMPLETING AND SUBMITTING REQUIRED REPORTING AND
25 PAPERWORK.

26 (G) NUMBER OF CONSUMERS SERVED.

27 (H) NUMBER AND TYPE OF LONG-TERM CARE SERVICES AND SUPPORTS

1 REFERRALS MADE.

2 (1) NUMBER AND TYPE OF LONG-TERM CARE SERVICES AND SUPPORTS
3 REFERRALS NOT COMPLETED, TAKING INTO CONSIDERATION THE REASONS WHY
4 THE REFERRALS WERE NOT COMPLETED, INCLUDING, BUT NOT LIMITED TO,
5 CONSUMER CHOICE, SERVICES NOT AVAILABLE, CONSUMER FUNCTIONAL OR
6 FINANCIAL INELIGIBILITY, AND FINANCIAL PROHIBITIONS.

7 (8) THE DEPARTMENT OF COMMUNITY HEALTH SHALL DEVELOP STANDARD
8 COST REPORTING METHODS AS A BASIS FOR CONDUCTING COST ANALYSES AND
9 COMPARISONS ACROSS ALL PUBLICLY FUNDED LONG-TERM CARE SYSTEMS AND
10 SHALL REQUIRE SINGLE POINT OF ENTRY AGENCIES TO UTILIZE THESE AND
11 OTHER COMPATIBLE DATA COLLECTION AND REPORTING MECHANISMS.

12 (9) THE DEPARTMENT OF COMMUNITY HEALTH SHALL SOLICIT PROPOSALS
13 FROM ENTITIES SEEKING DESIGNATION AS A SINGLE POINT OF ENTRY AGENCY
14 AND, EXCEPT AS PROVIDED IN SUBSECTION (16) AND SECTION 109J, SHALL
15 INITIALLY DESIGNATE NOT MORE THAN 4 AGENCIES TO SERVE AS A SINGLE
16 POINT OF ENTRY AGENCY IN AT LEAST 4 SEPARATE AREAS OF THE STATE.
17 THERE SHALL NOT BE MORE THAN 1 SINGLE POINT OF ENTRY AGENCY IN EACH
18 DESIGNATED AREA. AN AGENCY DESIGNATED BY THE DEPARTMENT OF
19 COMMUNITY HEALTH UNDER THIS SUBSECTION SHALL SERVE AS A SINGLE
20 POINT OF ENTRY AGENCY FOR AN INITIAL PERIOD OF UP TO 3 YEARS,
21 SUBJECT TO THE PROVISIONS OF SUBSECTION (6). IN ACCORDANCE WITH
22 SUBSECTION (17), THE DEPARTMENT SHALL REQUIRE THAT A CONSUMER
23 RESIDING IN AN AREA SERVED BY A SINGLE POINT OF ENTRY AGENCY
24 DESIGNATED UNDER THIS SUBSECTION UTILIZE THAT AGENCY IF THE
25 CONSUMER IS SEEKING ELIGIBILITY FOR MEDICAID LONG-TERM CARE
26 PROGRAMS.

27 (10) THE DEPARTMENT OF COMMUNITY HEALTH SHALL EVALUATE THE

1 PERFORMANCE OF SINGLE POINT OF ENTRY AGENCIES UNDER THIS SECTION ON
2 AN ANNUAL BASIS.

3 (11) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ENGAGE A
4 QUALIFIED OBJECTIVE INDEPENDENT AGENCY TO CONDUCT A COST-BENEFIT
5 ANALYSIS OF SINGLE POINT OF ENTRY, INCLUDING, BUT NOT LIMITED TO,
6 THE IMPACT ON MEDICAID LONG-TERM CARE COSTS.

7 (12) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE A SUMMARY
8 OF THE ANNUAL EVALUATION, ANY REPORT OR RECOMMENDATION FOR
9 IMPROVEMENT REGARDING THE SINGLE POINT OF ENTRY, AND THE COST-
10 BENEFIT ANALYSIS AVAILABLE TO THE LEGISLATURE AND THE PUBLIC.

11 (13) NOT EARLIER THAN 12 MONTHS AFTER BUT NOT LATER THAN 24
12 MONTHS AFTER THE IMPLEMENTATION OF THE SINGLE POINT OF ENTRY AGENCY
13 DESIGNATED UNDER SUBSECTION (9), THE DEPARTMENT OF COMMUNITY HEALTH
14 SHALL SUBMIT A WRITTEN REPORT TO THE SENATE AND HOUSE OF
15 REPRESENTATIVES STANDING COMMITTEES DEALING WITH LONG-TERM CARE
16 ISSUES, THE CHAIRS OF THE SENATE AND HOUSE OF REPRESENTATIVES
17 APPROPRIATIONS COMMITTEES, THE CHAIRS OF THE SENATE AND HOUSE OF
18 REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON COMMUNITY HEALTH,
19 AND THE SENATE AND HOUSE FISCAL AGENCIES REGARDING THE ARRAY OF
20 SERVICES PROVIDED BY THE DESIGNATED SINGLE POINT OF ENTRY AGENCIES
21 AND THE COST, EFFICIENCIES, AND EFFECTIVENESS OF SINGLE POINT OF
22 ENTRY. IN THE REPORT REQUIRED UNDER THIS SUBSECTION, THE DEPARTMENT
23 OF COMMUNITY HEALTH SHALL PROVIDE RECOMMENDATIONS REGARDING THE
24 CONTINUATION, CHANGES, OR CANCELLATION OF SINGLE POINT OF ENTRY
25 AGENCIES BASED ON DATA PROVIDED UNDER SUBSECTIONS (4) AND (10) TO
26 (12).

27 (14) BEGINNING IN THE YEAR THE REPORT IS SUBMITTED AND

1 ANNUALLY AFTER THAT, THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE
2 A PRESENTATION ON THE STATUS OF SINGLE POINT OF ENTRY AND ON THE
3 SUMMARY INFORMATION AND RECOMMENDATIONS REQUIRED UNDER SUBSECTION
4 (12) TO THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS
5 SUBCOMMITTEES ON COMMUNITY HEALTH TO ENSURE THAT LEGISLATIVE REVIEW
6 OF SINGLE POINT OF ENTRY SHALL BE PART OF THE ANNUAL STATE BUDGET
7 DEVELOPMENT PROCESS.

8 (15) THE DEPARTMENT OF COMMUNITY HEALTH SHALL PROMULGATE RULES
9 TO IMPLEMENT THIS SECTION NOT LATER THAN 270 DAYS AFTER SUBMITTING
10 THE REPORT REQUIRED IN SUBSECTION (13).

11 (16) THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT DESIGNATE
12 MORE THAN THE INITIAL 4 AGENCIES DESIGNATED UNDER SUBSECTION (9) TO
13 SERVE AS SINGLE POINT OF ENTRY AGENCIES OR AGENCIES SIMILAR TO
14 SINGLE POINT OF ENTRY AGENCIES UNLESS ALL OF THE FOLLOWING OCCUR:

15 (A) THE WRITTEN REPORT IS SUBMITTED AS PROVIDED UNDER
16 SUBSECTION (13).

17 (B) TWELVE MONTHS HAVE PASSED SINCE THE SUBMISSION OF THE
18 WRITTEN REPORT REQUIRED UNDER SUBSECTION (13).

19 (C) THE LEGISLATURE APPROPRIATES FUNDS TO SUPPORT THE
20 DESIGNATION OF ADDITIONAL SINGLE POINT OF ENTRY AGENCIES.

21 (17) A SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE SHALL
22 SERVE AS THE SOLE AGENCY WITHIN THE DESIGNATED SINGLE POINT OF
23 ENTRY AREA TO ASSESS A CONSUMER'S ELIGIBILITY FOR MEDICAID LONG-
24 TERM CARE PROGRAMS UTILIZING A COMPREHENSIVE LEVEL OF CARE
25 ASSESSMENT APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.

26 (18) ALTHOUGH A COMMUNITY MENTAL HEALTH SERVICES PROGRAM MAY
27 SERVE AS A SINGLE POINT OF ENTRY AGENCY TO PROVIDE SERVICES TO

1 INDIVIDUALS WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY,
2 COMMUNITY MENTAL HEALTH SERVICES PROGRAMS ARE NOT SUBJECT TO THE
3 PROVISIONS OF THIS ACT.

4 (19) FOR THE PURPOSES OF THIS SECTION:

5 (A) "ADMINISTRATIVE COSTS" MEANS THE COSTS THAT ARE USED TO
6 PAY FOR EMPLOYEE SALARIES NOT DIRECTLY RELATED TO CARE PLANNING AND
7 SUPPORTS COORDINATION AND ADMINISTRATIVE EXPENSES NECESSARY TO
8 OPERATE EACH SINGLE POINT OF ENTRY AGENCY.

9 (B) "ADMINISTRATIVE EXPENSES" MEANS THE COSTS ASSOCIATED WITH
10 THE FOLLOWING GENERAL ADMINISTRATIVE FUNCTIONS:

11 (i) FINANCIAL MANAGEMENT, INCLUDING, BUT NOT LIMITED TO,
12 ACCOUNTING, BUDGETING, AND AUDIT PREPARATION AND RESPONSE.

13 (ii) PERSONNEL MANAGEMENT AND PAYROLL ADMINISTRATION.

14 (iii) PURCHASE OF GOODS AND SERVICES REQUIRED FOR ADMINISTRATIVE
15 ACTIVITIES OF THE SINGLE POINT OF ENTRY AGENCY, INCLUDING, BUT NOT
16 LIMITED TO, THE FOLLOWING GOODS AND SERVICES:

17 (A) UTILITIES.

18 (B) OFFICE SUPPLIES AND EQUIPMENT.

19 (C) INFORMATION TECHNOLOGY.

20 (D) DATA REPORTING SYSTEMS.

21 (E) POSTAGE.

22 (F) MORTGAGE, RENT, LEASE, AND MAINTENANCE OF BUILDING AND
23 OFFICE SPACE.

24 (G) TRAVEL COSTS NOT DIRECTLY RELATED TO CONSUMER SERVICES.

25 (H) ROUTINE LEGAL COSTS RELATED TO THE OPERATION OF THE SINGLE
26 POINT OF ENTRY AGENCY.

27 (C) "AUTHORIZED REPRESENTATIVE" MEANS A PERSON EMPOWERED BY

1 THE CONSUMER BY WRITTEN AUTHORIZATION TO ACT ON THE CONSUMER'S
2 BEHALF TO WORK WITH THE SINGLE POINT OF ENTRY, IN ACCORDANCE WITH
3 THIS ACT.

4 (D) "GUARDIAN" MEANS AN INDIVIDUAL WHO IS APPOINTED UNDER
5 SECTION 5306 OF THE ESTATES AND PROTECTED INDIVIDUALS CODE, 1998 PA
6 386, MCL 700.5306. GUARDIAN INCLUDES AN INDIVIDUAL WHO IS APPOINTED
7 AS THE GUARDIAN OF A MINOR UNDER SECTION 5202 OR 5204 OF THE
8 ESTATES AND PROTECTED INDIVIDUALS CODE, 1998 PA 386, MCL 700.5202
9 AND 700.5204, OR WHO IS APPOINTED AS A GUARDIAN UNDER THE MENTAL
10 HEALTH CODE, 1974 PA 258, MCL 300.1001 TO 300.2106.

11 (E) "INFORMED CHOICE" MEANS THAT THE CONSUMER IS PRESENTED
12 WITH COMPLETE AND UNBIASED INFORMATION ON HIS OR HER LONG-TERM CARE
13 OPTIONS, INCLUDING, BUT NOT LIMITED TO, THE BENEFITS, SHORTCOMINGS,
14 AND POTENTIAL CONSEQUENCES OF THOSE OPTIONS, UPON WHICH HE OR SHE
15 CAN BASE HIS OR HER DECISION.

16 (F) "PERSON-CENTERED PLANNING" MEANS A PROCESS FOR PLANNING
17 AND SUPPORTING THE CONSUMER RECEIVING SERVICES THAT BUILDS ON THE
18 INDIVIDUAL'S CAPACITY TO ENGAGE IN ACTIVITIES THAT PROMOTE
19 COMMUNITY LIFE AND THAT HONORS THE CONSUMER'S PREFERENCES, CHOICES,
20 AND ABILITIES. THE PERSON-CENTERED PLANNING PROCESS INVOLVES
21 FAMILIES, FRIENDS, AND PROFESSIONALS AS THE CONSUMER DESIRES OR
22 REQUIRES.

23 (G) "SINGLE POINT OF ENTRY" MEANS A PROGRAM FROM WHICH A
24 CURRENT OR POTENTIAL LONG-TERM CARE CONSUMER CAN OBTAIN LONG-TERM
25 CARE INFORMATION, SCREENING, ASSESSMENT OF NEED, CARE PLANNING,
26 SUPPORTS COORDINATION, AND REFERRAL TO APPROPRIATE LONG-TERM CARE
27 SUPPORTS AND SERVICES.

1 (H) "SINGLE POINT OF ENTRY AGENCY" MEANS THE ORGANIZATION
2 DESIGNATED BY THE DEPARTMENT OF COMMUNITY HEALTH TO PROVIDE CASE
3 MANAGEMENT FUNCTIONS FOR CONSUMERS IN NEED OF LONG-TERM CARE
4 SERVICES WITHIN A DESIGNATED SINGLE POINT OF ENTRY AREA.

5 SEC. 109J. THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT
6 DESIGNATE MORE THAN THE INITIAL 4 AGENCIES DESIGNATED UNDER SECTION
7 109I(9) TO SERVE AS SINGLE POINT OF ENTRY AGENCIES OR AGENCIES
8 SIMILAR TO SINGLE POINT OF ENTRY AGENCIES UNLESS THE CONDITIONS OF
9 SECTION 109I(16) ARE MET AND THE LEGISLATURE REPEALS THIS SECTION.

Amendment No. 2a
September 19, 2006

House Bill No. 5389 2a

Rep. Shaffer moved to amend the bill as follows:

1. Amend page 12, following line 3, by inserting:

"(19) MEDICAID REIMBURSEMENT FOR HEALTH FACILITIES OR AGENCIES SHALL NOT BE REDUCED BELOW THE LEVEL OF RATES AND PAYMENTS IN EFFECT ON OCTOBER 1, 2006, AS A DIRECT RESULT OF THE 4 PILOT SINGLE POINT OF ENTRY AGENCIES DESIGNATED UNDER SUBSECTION (9)." and renumbering the remaining subsection.

HOUSE BILL No. 6478

September 14, 2006, Introduced by Reps. Vander Veen, Zelenko, Newell, Marleau, Brandenburg, Gaffney, Hummel, Caswell, Stahl, Amos, Green, Hansen, Booher, Sheen, Kahn and Huizenga and referred to the Committee on Senior Health, Security, and Retirement.

A bill to amend 1939 PA 280, entitled "The social welfare act," by amending sections 112b, 112c, and 112e (MCL 400.112b, 400.112c, and 400.112e), as added by 1995 PA 85; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 112b. As used in this section and sections 112c to 112e:

2 ~~— (a) "Home health care" means care described in section 109c.~~

3 **(A) "ASSET DISREGARD" MEANS, WITH REGARD TO THE STATE'S**
 4 **MEDICAL ASSISTANCE PROGRAM, DISREGARDING ANY ASSETS OR RESOURCES IN**
 5 **AN AMOUNT EQUAL TO THE INSURANCE BENEFIT PAYMENTS THAT ARE MADE TO**
 6 **OR ON BEHALF OF AN INDIVIDUAL WHO IS A BENEFICIARY UNDER A**
 7 **QUALIFIED LONG-TERM CARE INSURANCE PARTNERSHIP POLICY.**

8 (b) "Long-term care insurance policy" means a policy described

1 in chapter 39 of the insurance code of 1956, ~~Act No. 218 of the~~
 2 ~~Public Acts of 1956, being sections 500.3901 to 500.3955 of the~~
 3 ~~Michigan Compiled Laws 1956 PA 218, MCL 500.3901 TO 500.3955.~~

4 (C) "LONG-TERM CARE PARTNERSHIP PROGRAM" MEANS A QUALIFIED
 5 STATE LONG-TERM CARE INSURANCE PARTNERSHIP AS DEFINED IN SECTION
 6 1917(B) OF THE SOCIAL SECURITY ACT, 42 USC 1396P.

7 (D) "LONG-TERM CARE PARTNERSHIP PROGRAM POLICY" MEANS A
 8 QUALIFIED LONG-TERM CARE INSURANCE POLICY THAT THE COMMISSIONER OF
 9 THE OFFICE OF FINANCIAL AND INSURANCE SERVICES CERTIFIES AS MEETING
 10 THE REQUIREMENTS OF SECTION 1917(B) OF THE SOCIAL SECURITY ACT, 42
 11 USC 1396P, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION ACT OF
 12 2005, PUBLIC LAW 109-171, AND ANY APPLICABLE FEDERAL REGULATIONS OR
 13 GUIDELINES.

14 (E) ~~(e)~~ "Medicaid" means the program of medical assistance
 15 established by the department OF COMMUNITY HEALTH under section
 16 105.

17 ~~(d) "Nursing home care" means nursing home services as~~
 18 ~~described in section 109(1)(e).~~

19 ~~(e) "Partnership policy" means a long term care insurance~~
 20 ~~policy that meets the requirements set forth in section 112d.~~

21 ~~(f) "Partnership program" means the Michigan partnership for~~
 22 ~~long term care program established under section 112e.~~

23 Sec. 112c. (1) Subject to subsection ~~(4)~~ (5), the department
 24 OF COMMUNITY HEALTH IN CONJUNCTION WITH THE OFFICE OF FINANCIAL AND
 25 INSURANCE SERVICES AND THE DEPARTMENT OF HUMAN SERVICES shall
 26 establish ~~the Michigan partnership for long term care program~~ A
 27 LONG-TERM CARE PARTNERSHIP PROGRAM IN MICHIGAN to provide for the

1 financing of long-term care through a combination of private
2 insurance and medicaid. **THE LONG-TERM CARE PARTNERSHIP PROGRAM**
3 **SHALL DO ALL OF THE FOLLOWING:**

4 (A) PROVIDE INCENTIVES FOR INDIVIDUALS TO INSURE AGAINST THE
5 COSTS OF PROVIDING FOR THEIR LONG-TERM CARE NEEDS.

6 (B) PROVIDE A MECHANISM FOR INDIVIDUALS TO QUALIFY FOR
7 COVERAGE OF THE COST OF THEIR LONG-TERM CARE NEEDS UNDER MEDICAID
8 WITHOUT FIRST BEING REQUIRED TO SUBSTANTIALLY EXHAUST THEIR
9 RESOURCES.

10 (C) ALLEVIATE THE FINANCIAL BURDEN ON THE STATE'S MEDICAL
11 ASSISTANCE PROGRAM BY ENCOURAGING THE PURSUIT OF PRIVATE
12 INITIATIVES.

13 ~~—— (2) An individual is eligible to participate in the~~
14 ~~partnership program if he or she meets all of the following~~
15 ~~requirements:~~

16 ~~—— (a) Is a Michigan resident.~~

17 ~~—— (b) Purchases a partnership policy that is delivered, issued~~
18 ~~for delivery, or renewed on or after the effective date of this~~
19 ~~section, and maintains the partnership policy in effect throughout~~
20 ~~the period of participation in the partnership program.~~

21 ~~—— (c) Exhausts the minimum benefits under the partnership policy~~
22 ~~as described in section 112d(1)(a). Benefits received under a long-~~
23 ~~term care insurance policy before the effective date of this~~
24 ~~section do not count toward the exhaustion of benefits required in~~
25 ~~this subdivision.~~

26 ~~—— (3) Upon application of an individual who meets the~~
27 ~~requirements described in subsection (2), the department shall~~

1 ~~determine the individual's eligibility for medicaid in accordance~~
2 ~~with both of the following:~~

3 ~~—— (a) After disregarding financial assets exempted under~~
4 ~~medicaid eligibility requirements, the department shall disregard~~
5 ~~an additional amount of financial assets equal to the dollar amount~~
6 ~~of coverage under the partnership policy.~~

7 ~~—— (b) The department shall consider the individual's income in~~
8 ~~accordance with medicaid eligibility requirements.~~

9 ~~—— (4) The department shall seek appropriate amendments to the~~
10 ~~medicaid state plan and shall apply for any necessary waiver of~~
11 ~~medicaid requirements by the federal health care financing~~
12 ~~administration to implement the partnership program.~~

13 ~~—— (5) The department shall not implement the partnership program~~
14 ~~unless both of the following apply:~~

15 ~~—— (a) A federal waiver of medicaid requirements is obtained, if~~
16 ~~necessary.~~

17 ~~—— (b) Federal law exempts individuals who receive medicaid under~~
18 ~~this section from estate recovery requirements under section 1917~~
19 ~~of title XIX of the social security act, 42 U.S.C. 1396p.~~

20 **(2) AN INDIVIDUAL WHO IS A BENEFICIARY OF A MICHIGAN LONG-TERM**
21 **CARE PARTNERSHIP PROGRAM POLICY IS ELIGIBLE FOR ASSISTANCE UNDER**
22 **THE STATE'S MEDICAL ASSISTANCE PROGRAM USING THE ASSET DISREGARD AS**
23 **PROVIDED UNDER SUBSECTION (5).**

24 **(3) THE DEPARTMENT OF COMMUNITY HEALTH MAY ENTER INTO**
25 **RECIPROCAL AGREEMENTS WITH OTHER STATES TO EXTEND THE ASSET**
26 **DISREGARD TO MICHIGAN RESIDENTS WHO PURCHASED LONG-TERM CARE**
27 **PARTNERSHIP POLICES IN OTHER STATES THAT ARE COMPLIANT WITH TITLE**

1 VI, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION ACT OF 2005,
2 PUBLIC LAW 109-171, AND ANY APPLICABLE FEDERAL REGULATIONS OR
3 GUIDELINES.

4 (4) UPON THE EXHAUSTION OF BENEFITS OR UPON THE DIMINISHMENT
5 OF ASSETS BELOW THE ANTICIPATED REMAINING BENEFITS UNDER A LONG-
6 TERM CARE PARTNERSHIP PROGRAM POLICY, CERTAIN ASSETS OF AN
7 INDIVIDUAL, AS PROVIDED UNDER SUBSECTION (5), SHALL NOT BE
8 CONSIDERED WHEN DETERMINING ANY OF THE FOLLOWING:

9 (A) MEDICAID ELIGIBILITY.

10 (B) THE AMOUNT OF ANY MEDICAID PAYMENT.

11 (C) ANY SUBSEQUENT RECOVERY BY THE STATE OF A PAYMENT FOR
12 MEDICAL SERVICES.

13 (5) NOT LATER THAN 180 DAYS AFTER THE EFFECTIVE DATE OF THE
14 AMENDATORY ACT THAT ADDED THIS SUBSECTION, THE DEPARTMENT OF
15 COMMUNITY HEALTH SHALL APPLY TO THE UNITED STATES DEPARTMENT OF
16 HEALTH AND HUMAN SERVICES FOR AN AMENDMENT TO THE STATE'S MEDICAID
17 STATE PLAN TO ESTABLISH THAT THE ASSETS AN INDIVIDUAL OWNS AND MAY
18 RETAIN UNDER MEDICAID AND STILL QUALIFY FOR BENEFITS UNDER MEDICAID
19 AT THE TIME THE INDIVIDUAL APPLIES FOR BENEFITS IS INCREASED
20 DOLLAR-FOR-DOLLAR FOR EACH DOLLAR PAID OUT UNDER THE INDIVIDUAL'S
21 LONG-TERM CARE INSURANCE POLICY IF THE INDIVIDUAL IS A BENEFICIARY
22 OF A QUALIFIED LONG-TERM CARE PARTNERSHIP PROGRAM POLICY.

23 (6) IF THE LONG-TERM CARE PARTNERSHIP PROGRAM IS DISCONTINUED,
24 AN INDIVIDUAL WHO PURCHASED A MICHIGAN LONG-TERM CARE PARTNERSHIP
25 PROGRAM POLICY BEFORE THE DATE THE PROGRAM WAS DISCONTINUED SHALL
26 BE ELIGIBLE TO RECEIVE ASSET DISREGARD IF ALLOWED AS PROVIDED BY
27 TITLE VI, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION ACT OF

1 2005, PUBLIC LAW 109-171.

2 (7) THE DEPARTMENT OF COMMUNITY HEALTH MAY CONTRACT WITH A
3 NONPROFIT ORGANIZATION TO PROVIDE COUNSELING SERVICES UNDER THE
4 MICHIGAN LONG-TERM CARE PARTNERSHIP PROGRAM.

5 Sec. 112e. The department OF COMMUNITY HEALTH may promulgate
6 rules pursuant to the administrative procedures act of 1969, ~~Act~~
7 ~~No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328~~
8 ~~of the Michigan Compiled Laws 1969 PA 306, MCL 24.201 TO 24.328,~~
9 as necessary to implement the partnership program IN ACCORDANCE
10 WITH THE REQUIREMENTS OF SECTION 1917(B) OF THE SOCIAL SECURITY
11 ACT, 42 USC 1396P, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION
12 ACT OF 2005, PUBLIC LAW 109-171, AND APPLICABLE FEDERAL REGULATIONS
13 OR GUIDELINES.

14 Enacting section 1. Section 112d of the social welfare act,
15 1939 PA 280, MCL 400.112d, is repealed.

Medicaid Infrastructure Grant (MIG) Update September 12, 2006

There are presently 805 Freedom to Work (FTW) participants in 72 counties. This is a reduction by 4 participants from the 809 in August. MIG staff is researching why individuals have disenrolled or become ineligible from the start of FTW.

MIG outreach in September includes the following conferences:

- Michigan Works on 9/10 & 11
- RICC/MDDC on 9/12 & 13
- Michigan Assn for Persons in Supported Employment on 9/15
- Person Centered Planning Conference on 9/19 & 20
- Correctional Re-entry Employment Fair in Grand Rapids on 9/29

An updated table noting action on barriers to FTW will be forwarded in addition to these minutes. Medical Services Administration (MSA) remains instrumental in helping address these barriers to FTW.

The MIG is partnering with the MiJob Coalition and collaborating with the newly incorporated Michigan Business Leadership Network (BLN) as it initiates outreach throughout Michigan to establish local/regional BLNs. This will provide much needed representation by the employer community as we strive to provide more work opportunities for persons with disabilities. Joe Longcor and Tony Wong will be attending the National Business Leadership Conference in Minneapolis, MN on October 4-6, to further understand how the MIG and MiJob Coalition may better work with employers.

The MIG and MiJob Coalition is also working with the public TV show Disabilities Today and DCH to create a show focusing on FTW to be aired by the end of the year. We also expect to have public service announcements created that will also be used to further promote FTW.

Independence Plus (IP)/Money Follows the Person (MFP) Grants September 12, 2006

The extension requests for the IP and MFP Grants were submitted for review and approval in August. At this time, the MFP extension has been approved formally and the IP informally. The budgets are set and plans are underway to continue work on both initiatives. Contracts to support the grant efforts have been developed with MDRC and MACMHB.

The MFP activities planned are; research on the impact of self-determination, training in Person-Centered Planning, consumer involvement, nursing home transition supports and supports for a workgroup to complete work on a 1915 (b) (c) waiver

The IP effort includes training, technical assistance document production, consumer involvement, research and new waiver development. The training will be focused on supporting self-determined arrangements through train-the-trainer activities for mental health consumers and support system others. Below are the training priorities from the needs data.

Both grants rely in consumer input and direction to make progress. The continued success of our mutual agenda requires new voices and perspectives for how to make consumer direction work in Michigan.

Based on the responses from participants at the Determination Implementation Leadership Seminars, the following training needs have been identified as priorities:

1. Orientation to Self-Determination for Consumers and Families
2. Role Transition for Case Managers to Supports Coordinators
3. Working with Fiscal Intermediaries, Contractual Agreements and Individual Budgets

Other training topics requested are:

- A basic orientation to the concepts and methods of Self-Determination
- Facilitating Person-Centered Planning
- Consumers as Employers
- How to make Self-Determination work for persons with serious mental illness.
- Developing and Using Independent Supports Brokers and Facilitators
- Training for Personal Assistants
- Orientation to the MDCH site-review standards for Self-Determination
- Alternatives to Guardianship

You can view the contents of the past Self-Determination Implementation Leadership Training events at www.macmhb.org and then scroll down the left margin and click on the Self-Determination logo.

The Train-the-Trainer for the “Consumers as Employers” class, delivered by the Paraprofessional Healthcare Institute started with 22 participants. This course began on September 8 and runs till November 10th. Participants are teams of staff and consumers from local communities. The purpose is to prepare these teams to deliver the course in local communities, providing consumers with practical information on hiring, managing and communicating with Personal Assistants.

The Person-Centered Planning Discovery team is hosting a 2-day training on Person-Centered Thinking Skills with national consultant Michael Smull on September 25 & 26 in Lansing. Another event, called “Training for Fiscal Intermediaries and Those Who Work With Them”, conducted by Susan Flanagan will be held on September 28 & 29, also in Lansing. Please call Rob Curtner (517 335-8710) if you wish to be involved in these training opportunities. The 9th annual PCP conference is on September 19 & 20 in Kalamazoo.

Self- Determination in Long Term Care Project September 14, 2006

CMS sent questions and feedback on the waiver amendment application. This has been responded to and re-submitted.

The target date for enrolling participants is October 1.

Training sessions on person centered planning and fiscal management will be held during the last week of September.

Policy and practice guidelines for Person Centered Planning are almost ready for review.

The quality measurement process and the phase in plan for the rest of the state are the priorities being addressed at this time.

October begins the final year of the grant funding from Robert Wood Johnson.

ACTION/ASSISTANCE ITEMS

Attached are the several printed pieces to give to potential participants. Please review and give feedback to Tari.

We are still struggling with name for this project that is shorter. Any and all suggestions are welcome.

Aging and Disabled Resource Center/Single Point of Entry

September 14, 2006

All four regional centers have acting directors. They are Earlene Traylor Neal for Detroit, Mark Bomberg for Upper Peninsula, John Altena for South West Michigan and Charles Logie for West Michigan. The acting directors have begun hiring key staff and creating governing boards and advisory groups. Once boards are in place, they will determine a process to confirm or change the director.

Service Point has been selected as the soft ware package and the MIS workgroup is identifying core data elements that will be built into the system. Among other things, the software will track who calls, source of referrals, types of information provided, unmet needs and follow-up activities.

The Interagency workgroup members need to collaborate to assure the SPE staffs have the skills and SPE sites have access to conduct Level of Care Determinations. In addition, the group endorsed a revised and more detailed work plan to streamline financial and functional eligibility.

The Functions workgroup is continuing the work of writing standards for Information and Assistance Service and for Options Counseling. The workgroup will include clear requirements to assure that all persons who access SPE service receive a full explanation of their rights. The group has also begun to develop a training agenda. Experts from existing systems and organizations are being identified to assist with training. **The Consumer Task Force is invited to make suggestions.**

The goal is to have the SPE open to provide information and assistance by October 1, 2006. (Not every county in every area will be open on October 1).

The first Informational forum was held on Monday August 28. Over a hundred persons attended. Mike Head, Nora Barkey, Earlene Traylor Neal and John Altena provided an update. In addition over 40 questions were asked and answered. Copies of materials presented will be made available on a web site within the next month.

MQCCC
Overview of County Activities

We have met with DHS in all of the 83 counties in the state of Michigan!

We have held Introductory Sessions in 75 counties.

3 more counties have Introductory Sessions already scheduled.

Allegan Branch Schoolcraft

In 4 counties we have had no response to the mailing.

Alcona Charlevoix Keweenaw
Leelanau

In 2 counties we have had responses but, have as yet, been unable to connect with the providers to set up an Introductory Session.

Kalkaska Mackinac

There are over 360 approved providers in 55 counties.

The 23 counties where we do not have providers include 9 counties listed above (excluding Wayne where we do have 2 approved providers). In addition to these we do not have providers in:

Alger ¹	Baraga ²	Berrien ¹
Gratiot ²	Hillsdale ¹	Houghton
Huron ²	Iron ¹	Lenawee ¹
Luce ¹	Manistee ¹	Mason ¹
Montmorency ²	Oceana ¹	

¹ Has providers pending approval.

² Have tried to hold introductory sessions but the providers either didn't show or were from another county.

We have served over 220 consumers in 18 counties.

ADAPT Press Releases
For Immediate Release:
September 9, 2006

For Information Contact:
Bob Kafka 512-431-4085
Marsha Katz 406-544-9504

National Hearing Testimony Should Convince States to Apply for MFP Funds

Washington, D.C. --- Recently passed federal legislation provides states with extra funds to move people with disabilities and older persons out of nursing homes, and back into their own homes in the community. Any states left wondering whether or not to take advantage of this federal initiative, known as "Money Follows the Person," (MFP), need only review testimony from the just-released transcript of the National Hearing on Ending Institutional Bias in Long-Term Services and Supports.

"I don't know how anyone can read story after story of the 70 people who testified, and not be moved to do whatever it takes to give people a choice in where they live and receive their long-term services and supports," said National ADAPT Organizer Stephanie Thomas. "Michael Taylor, from Memphis, desperately wanted out of the nursing home had been forced into, but had to have someone else read his statement because the nursing home refused to let him come to the hearing to speak for himself."

In March 2006, in a virtually unprecedented national forum sponsored by ADAPT, officials from the US Department of Health and Human Services (HHS), the National Council on Disability (NCD), the National Council on Independent Living (NCIL), the American Association of People with Disabilities (AAPD), ADAWatch, and the National Disability Rights Network (NDRN) heard the testimony of people from all over the country who have lived through the indignities, and even horrors, of institutionalization.

Samuel Mitchell, an ordained minister and former truck driver who became disabled, testified, "I had a ministry to nursing homes. I went in nursing homes and preached. I thought I knew a little bit about them. After becoming disabled, a year later I suffered a stroke. That's when I entered a nursing home, and I found out just how much I didn't know about nursing homes. The prevailing atmosphere in nursing homes is that we now own you. You become a non-person. Your rights, human rights and civil rights are routinely violated. Dignity, there was no dignity. I can remember sitting using the rest room and having a CNA come in the door and start washing something out, and I told her 'you can't be in here.' She said, 'I'm going to only be a minute, don't worry, Mr. Mitchell.'" Mitchell eventually left the nursing home, and is now an ADAPT Organizer in Georgia, married and living in his own home,.

"I call nursing homes death camps," testified a Philadelphia woman known as Spitfire." I am Jewish, I qualify. What they did to me? Stage 4 bedsores, rape and torture sound familiar? But I live independently now. I was rescued by a friendly visitor with an

ADAPT T-shirt. I love living on my own. I'm a good cook. I do my own ADLs. I know when to go to sleep. I'm not going to be raped at night. I know I won't have bed sores. I have a wonderful attendant."

Daniel Remick told the national hearing panel, "I am 58 years old. I was institutionalized at 8 and a half. My rights were taken away from me because of my disability. My mom and dad were told that I would never be able to live on my own because I did not have physical ability to do normal activity. Which [it] was a lie. I was sexually assaulted by an aide there."

Teresa Grove from Illinois said, "I am emotionally and mentally disabled. I've been in an institution since I was 14 years old. I was initiated in an institution by all the girls with a broom handle. I was told by a staff person and a security guard that I was whining and I should be quiet and grow up. [Now] I live in the community, but I live under an ongoing threat of one more admission anywhere, and I will be placed forever in a nursing home. Thank you."

States have until November 1, 2006, to submit applications for the additional federal funds to help them re-balance their long-term services and supports funding away from institutions and toward community-based alternatives. The full transcript from the National Hearing on Ending Institutional Bias in Long-Term Services and Supports, held in Nashville, Tennessee, March 19, 2006 can be found at <http://www.adapt.org/freeourpeople/aar/nash06/transcript.htm>

Michigan Department of Community Health
Office of Long-Term Care Supports & Services
Single Point of Entry Informational Forum
August 28, 2006

Participant Questions and Responses

Nursing Home Transition to the Community

Q1 *If we have residents in Macomb County who live in Wayne County/Detroit, will we be able to refer them to the Detroit SPE for services? Will they have to go to the site, or will services be offered “in home” as well?*

A1 Detroit SPE services are available to any person who resides in its geographic service area. Options counselors will be available to make in-home visits if necessary to meet the needs of the consumer.

Hospital Discharge Planning

Q2 *How will discharges from hospitals be affected?*

A2 The aim of having a single point of entry entity involved with individuals hospitalized and in need of long-term care services is to assist these individuals and those closest to them in knowing options available, and in accessing those options that are preferred by the individual. Thus, the point of involvement for options counseling is at the earliest point at which it appears that LTC services will be needed. This may not be known until some time during the course of hospital care, but in some cases it may be a matter known at the point of admission or even prior to that point. Early involvement will best assist the individual as well as health care providers in partnering to provide prompt information and options counseling. Local memorandums of understanding between the hospital and the SPE are intended to assure that options counselors are readily available, even co-located in hospital settings, to assist informed decision-making prior to discharge for the hospital patient in need of long term care services. Options counselors will not impede the discharge process; their involvement ought to facilitate the best outcome for the individual at that time, and in doing so, aid the hospital in achieving a timely and appropriate discharge.

Q3 *Will the SPE be involved at the hospital level in terms of discharge planning and does it involve just Medicaid patients?*

A3 Through local memorandums of understanding, the SPE will have options counselors available to serve all hospitals in the SPE’s geographic service area. The options counselors will assist the hospital’s discharge planners in planning for the patient’s post-hospital residential arrangements and care needs.

Coordination

- Q4** *What coordination will be required between the Detroit SPE and the Henry Ford PACE program?*
- A4** While not required, coordination between programs is encouraged to ensure that individuals are provided with the information and assistance needed to plan for and access long term care services. At a minimum, as the primary point of entry into Medicaid-funded long term care services, the SPE will act as a referral source for individuals wishing to enroll in the PACE program where one exists.
- Q5** *How will the SPE affect the LTC counseling currently done by CBC and MMAP? Both programs have a long history of providing this service.*
- A5** It is expected that the SPE will work closely with local stakeholders, including CBC and MMAP, to ensure the efficient and effective delivery of options counseling to individuals who need it. It is anticipated that CBC and MMAP will be collaborative partners of local SPE entities, acting as both a source of referrals for as well as the recipient of referrals from the SPE. Both are important partners in delivering benefits counseling services in the community.
- Q6** *Will the SPE demonstration projects be coordinated with the joint DCH/MSHDA affordable assisted living initiative that was recently unfolded?*
- A6** Yes to the extent they are serving the same geographic service area. SPEs will be responsible for working with both residents and housing managers to provide information and assistance in long term care residential planning. They will further be responsible for conducting level of care determinations for individuals wishing to access Medicaid-funded supports and services and facilitating person centered planning.
- Q7** *When do you anticipate the beginning of operational interface/referrals into the PIHP systems and supporting/serving the developmentally disabled population? How can PIHPs and supports coordinating agencies assist in the process?*
- A7** The SPEs are intended to serve the elderly and adults with disabilities. The only planned interface with the mental health/developmental disabilities PIHP system is for those individuals who are eligible for and require services from that system whose initial contact is with the SPE entity, and for those who may require LTC services in addition to services available through the mental health/developmental disabilities system. Individuals who are eligible for services through the public mental health system are the responsibility of the mental health/developmental disabilities system.
- Q8** *Can you explain the impact of the SPE on OBRA and dementia exception status?*
- A8** The SPE has no impact on OBRA.

Intake

Q9 *How will this affect the admission process to nursing homes?*

A9 Because use of the SPE is not mandatory, the initial affect on nursing homes will be limited. It is hoped that nursing homes will voluntarily partner with SPEs to conduct the required level of care (LOC) determination for new admissions. As an incentive, MDCH aims to develop policy guidance that will not hold nursing homes responsible for the cost of care provided to individuals who are incorrectly deemed eligible by the SPE using the LOC tool.

Q10 *Last year the state rolled out a level of care determination tool to determine if a person is appropriate for nursing home care. Will there be an equivalent objective tool across all levels of care or will the appropriate level of care be determined subjectively.*

A10 Medicaid law and regulation dictates that a state utilize the same method to determine eligibility for LTC for nursing facilities, PACE programs and the state's Home & Community Based Services programs, in Michigan's case, MI Choice. If and when the LOC methodology is modified, it will be applied in a similarly standard manner. Therefore, eligibility for nursing facility care will not be determined in a subjective or arbitrary manner.

Training

Q11 *Will there be a statewide uniform training curriculum for SPE staff including specific modules in issues such as mental health, younger disabled consumers, dementia, etc.?*

A11 To achieve a consistent and quality response across demonstration sites, uniform guidance will be provided. Local SPE entities will also be expected to work with their local counterparts in assuring that these needs and service options are commonly understood at the local level.

Q12 *How are you involving/educating case managers and social workers in the acute care settings about the SPE program in an effort to better educate/direct their clients to the appropriate settings and services post a hospital stay?*

A12 A primary focus of SPE outreach will be to work with acute care practitioners to increase their knowledge and acceptance of post-hospitalization options other than nursing facilities. To the extent that these practitioners are unaware of all of the options for LTC supports and services, they will be unable to assist in helping individuals know the range of opportunities.

Housing

Q13 *Will Medicaid pay for assisted living services if the consumer desires?*

A13 Currently, the MI Choice waiver may provide services to individuals who live independently, so those residing in unlicensed assisted living settings may receive support from the MI Choice program. At this time, the MI Choice waiver program does not provide services to individuals who are cared for in licensed residential care (Adult Foster Care or Homes for the Aged) settings

that are unlicensed. The Long-Term Care Task Force recommended that this option be added to the Medicaid program. Therefore, during the upcoming planning process for the MI Choice waiver renewal application, this option will be carefully considered. It is felt by many that individuals who now have no choice, but to enter a nursing facility when MI Choice waiver services in their home are not working, would be able to receive appropriate care in specialized licensed residential settings, were the MI Choice waiver program to include this option. Making this change will necessitate a careful examination of approaches to meet the added cost of this waiver service. Medicaid, however, may not be used to pay the costs of room and board in these licensed residential settings; Medicaid only pays the cost of room and board, in addition to care, in licensed institutional care settings, e.g. hospitals and nursing facilities.

Q14 *If Medicaid money is used for AFC and assisted living, will there be regulations and inspections like nursing homes?*

A14 “Assisted living” is not a statutorily defined type of care. Some settings denoted as assisted living are unlicensed; others are licensed. In unlicensed settings the individual is deemed to be in an independent living arrangement and existing MI Choice waiver program standards apply. In a licensed setting, the provider has a statutorily defined responsibility to assure for room and board as well as care, and the resident is typically dependent upon the provider. Licensing requirements impose standards for the care and residential support that must be furnished by the provider, and there are annual inspections as well as complaint investigations. The regulations governing these, however, are not the same as those governing nursing facilities. If the MI Choice waiver is expanded to pay for care in licensed residential care settings, there will likely be a set of standards that accompany the use of these specialized funds as there are for the use of specialized funds for such settings through the mental health system. To date, no planning work has been conducted towards this expanded option.

Q15 *As assisted living facilities pop up and offer increasingly more “clinical” services, will the state take an active role in regulating them?*

A15 In Michigan, assisted living is a marketing tool to describe housing with supports; there is no current governmental denotation of any care arrangement as “assisted living.” Adult foster care homes and homes for the aged are housing with supports models that are licensed by the state. The OLTCSS is concerned that consumers be protected from misleading marketing and will examine options for regulatory and other mechanism to support quality. State regulation of unlicensed assisted living would require a statutory basis in legislation enacted by the Michigan Legislature.

Options Counseling

Q16 *Is there a definition of options counseling in place? How does it differ from care management?*

A16 A care manager conducts the assessment and leads the service planning process for an individual eligible for MI Choice services, using a person-centered planning process. The care manager subsequently oversees the authorization of services in accordance with the service plan, then monitoring the provision of those services by providers chosen by the person who furnish the

services. An options counselor works with the individual in need of LTC assistance along with others the individual chooses to involve, in order to assist the person to examine available options and to facilitate an understanding of options in line with the person's preferences. The options counselor may even assist the person to develop a general support plan, and will assist them in understanding and obtaining access to desired services. Options counselors may, with the agreement of the person, periodically review the person's service arrangements and assist them with transitioning from one care arrangement to another over time, based on need and preferences.

Q17 *Will options counselors perform a thorough assessment of consumers' needs, strengths, dreams, etc.?*

A17 Options counselors will engage individuals in need of LTC assistance in a dialogue to determine needs, strengths and preferences, including facilitation of discussions among the person and those closest to them about options and how they may align with the person's preferences. Individuals will be provided with information about all long term care options and assisted to examine how these meet their needs and preferences. A general plan support plan incorporating the consumer's choices will be developed. Referrals to providers will be made based on the plan. Options counselors will also conduct the functional eligibility determination and will assist in preparation of application for financial eligibility.

Q18 *Will options counselors follow consumers from one setting to another? How will that take place?*

A18 Options counselors will maintain regular contact with consumers, they will review with the consumer their goals and expectations. Help with transition from one setting to the next, when desired, will be provided.

Q19 *If the SPE won't be developing person centered plans, will every provider be required to develop a person centered plan?*

A19 The options counselors will develop, with the consumer a general support plan that identifies settings, but does not provide for the detailed care assessment or care plan that would be done by the consumer's chosen provider. This will be done using the principles of person-centered planning. The general support plan will give the provider a good basis for understanding the client's preferences and choices. The provider will be expected to develop the individual's specific plan of services and supports, and to authorize needed services as a result, within the scope of the provider's responsibilities. In doing so, the provider should use a person-centered planning process which engages others chosen by the consumer, and which facilitates discussion of the person's whole life, their preferences and the best way to meet their long-term care needs in ways that achieve those preferences.

Impact on DHS

Q20 *As the SPE progresses and information and assistance expands, DHS workers – Medicaid and Adult Home Help Workers – will be greatly impacted. How do you plan to offset the increased workload for these DHS workers?*

A20 DCH has committed to work in partnership with DHS to measure the added impact this initiative has on DHS workers. A process will be developed jointly with DHS to establish baseline workload demands and track change on a county-by-county basis, ascertaining the extent to which changes are due to SPE activity. The two Departments are committed to jointly advocate for increased funding through the state budget process to address identified staffing shortages, should they occur, within the SPE counties.

Impact on MI Choice Waiver

Q21 *How many new waiver slots will be available so that SPEs can offer real choices?*

A21 The original intent was to assure 350 waiver slots for use within SPE regions. The segmenting of the LTC funds to separate appropriations lines in the MDCH FY 2007 budget may impede achieving this intent, as funds cannot be made readily available by the department for additional waiver slots. The department will continue to monitor the costs and projected savings associated with SPE activity. As the state's budget permits, MDCH will work with the legislature to expand the number of MI Choice waiver slots that might be made available to the SPEs. It is expected that a better sense of how to address this need can be accomplished within the next three months.

Q22 *How can you offer true options when there is a 3,000 person waiting list for the MI Choice waiver right now?*

A22 It will be a challenge; without sufficient resources the options will necessarily be limited. The SPE demonstrations were never intended to be the single method by which the many issues involving LTC and resource needs should be addressed. Concerned parties must continue their advocacy roles. Progress toward increasing options in the delivery of LTC supports and services in different settings will be incremental. A pivotal role of the SPE will be to quantify the need for expanded community-based care options and demonstrate the necessity for implementation of funding mechanisms that allow money to follow the person into their desired setting of care. In any event, the SPE will be in a good position to monitor need and demand, and measure actual disposition and cost-benefits as compared to desired disposition and alternative cost-benefits.

Q23 *How do you anticipate access to the MI Choice program changing in regions with SPEs?*

A23 The MI Choice program is not being changed in those areas with SPE demonstration projects. If the department can find ways to provide increased waiver options in the SPE regions, a method for authorizing access to these waiver options will be developed such that an individual may choose their preferred waiver agent through which they may use their waiver option. But at this time, this is merely a concept. SPEs will play a critical role in linking individuals in need of and who desire community-based long term care with a local waiver agency for ongoing case management and delivery of in-home services. It is also expected that SPE demonstration projects will enter into collaborative agreements with the MI Choice waiver agents in order to conduct the level of care eligibility determinations for those under consideration for MI Choice.

Miscellaneous

Q24 *Can you walk us through a “typical SPE scenario” for John Doe, age 67, on Medicare and Medicaid, currently in an acute care hospital, will need nursing home care, then home health services. How will a SPE assist John?*

A24 A hospital discharge planner will engage an SPE options counselor to evaluate John’s functional eligibility for long term care while still in the hospital. Using a person-centered planning process, the options counselor and John (and his chosen allies) will discuss his strengths and preferences and how his needs can be met within these preferences. During and as a result of this process, John and his chosen allies are better supported to evaluate options and make service decisions. The options counselor will assist him with accessing his desired service options for which he is eligible. The options counselor will contact John subsequent to his discharge (including during a Medicare-covered skilled nursing facility stay) to discuss ongoing needs, experiences and preferences and to continue to assist with knowing the full range of options available. If John is in a nursing facility and expresses a desire to live elsewhere, the options counselor will assist John in planning his transition.

Q25 *Please explain how this process will work if either I am a consumer seeking help or a social worker advocating on behalf of a consumer needing more care.*

A25 Whether you are a consumer or a social worker advocating on behalf of a consumer, a call to the SPE will result in a telephone conversation to determine the information and assistance needs. When appropriate, an in-person interview between the options counselor, the consumer and his/her chosen allies to review options and begin the planning process will be arranged.

Q26 *Since the SPEs are funded by Medicaid, obviously Medicaid recipients will be served free of charge. Is it anticipated that SPE services will also be provided to those who are not eligible for Medicaid on a fee-for-service basis? How might this work? Will this be required of the SPEs?*

A26 Information and assistance will be provided to all callers at no charge. Individuals who are not financially eligible for Medicaid will be offered an opportunity to participate in options counseling on a cost-shared or fee-for-service basis. This effort is essential to helping individuals with resources to plan for and access desired services. A primary goal of the SPE is to assist all Michigan citizens with LTC needs. Aiding individuals with resources may assist them in efficiently using their own resources to meet LTC needs, and thus delay their need for Medicaid funded services.

Q27 *Where does home health care fit into the SPE process?*

A27 Home health care services funded by Medicare and/or Medicaid must be prescribed by a physician. The SPE will help individuals and their caregivers to understand the range of available benefits and assist them in accessing the services they choose. Each SPE is developing an expanded resource data base that will include such services. In addition, it is expected that information to help callers be informed shoppers will be provided.

- Q28** *The Office of LTC Supports and Services has a great deal of staff with background/ expertise with the AAAs and MI Choice Waiver. What expertise and experience does this office have regarding the DHS home help services program and Medicaid eligibility?*
- A28** The OLTCSS has staff experienced with Medicaid eligibility determination process, as well as staff very familiar with the Home Help program. When its staff does not have knowledge or experience in a particular area, the Office will collaborate with staff from other departments and agencies. Policy changes and enhanced dialogue will occur through an interagency workgroup.
- Q29** *What plans do you have to fund an external advocate for the SPEs as recommended by the Task Force?*
- A29** Even though supported by Task Force recommendations, funding is not available at this time to fund an external advocate. In the absence of an external advocate, the Office is committed to ensuring that protocols are in place to ensure that Medicaid persons served by a SPE are fully informed of their right to a fair hearing, and that grievance and appeals processes are in place to resolve issues for non-Medicaid persons. Discussions will continue on external advocacy and its specific role, as well as an examination of the funding options that might be tapped to provide external advocacy.
- Q30** *What are the locals doing about assuring an external advocate is available from the beginning?*
- A30** Each SPE is creating partnerships at the local level that will have, or in the future will have, an ombudsman program.
- Q31** *Since these are pilot projects was consideration given to testing different design models?*
- A31** Many models were considered. The existing pilots are using several approaches to partnership, governance, and purchased services. In all cases, the pilots are working to build on existing services and to not duplicate services.
- Q32** *What is the rationale for not awarding planning grants to previous applicants?*
- A32** DCH wants to ensure the broadest participation possible in the local planning process and believes that awarding a planning grant to a neutral entity (i.e., a community college or regional United Way) will achieve that result. It would be perceived as creating an unfair advantage if applicants in the initial round were provided planning grants when other interested parties are not.
- Q33** *If the SPEs will cost \$34 million over 27 months, why is only \$9 million budgeted for SPEs in the '07 budget?*
- A33** When the budgets for the entire 27 month period of the demonstration project were being allocated, it was believed that it would take the SPEs a period of time to “ramp-up” to full operations. If it turns out that the SPEs are able to do this sooner, adjustments can and will be made in budget allocations for the project.

Q34 *Is the LTC office pursuing all avenues to make mandatory referral a reality? When will that happen?*

A34 The Office is not currently pursuing mandatory referral, as this appears to be not possible in a partial SPE system. Mandatory referral for LOC determinations is a component of pending legislation (HB 5389) and is desirable in the long run. Discussions with the CMS regional office are being planned to ascertain whether it is possible under current regulations to put a mandatory referral process in place.

Q35 *Please explain the component of local partners under the SPE project. What types of providers, services, agencies, etc., can become a local partner? How do I, as a provider, go about establishing a local partnership with the SPE in my area and what can I do to ensure this partnership flourishes (is very active)?*

A35 SPEs were required to involve consumers and local stakeholders in the planning process. The variety of stakeholders varies from one site to the next but is intended to include consumers, advocates and providers at a minimum. Any interested party can participate as a local stakeholder, providing input at public forums, and volunteering to serve on local workgroups and committees. Those interested in participating in local planning and governance should contact the SPE in their area to inquire about the process being used to involve stakeholders.

Q36 *Please explain in more detail the nomination processes for governing and advisory board. Who will be eligible to serve? How does one get nominated? Etc.?*

A36 Boards will be comprised of primary and secondary consumers as well as provider organization representatives. Individuals wishing to participate in governing and advisory boards at the local level should contact the individual SPE in their area for information on how to apply.

Q37 *Please tell us about the extent of consumer involvement in the workgroups and how that can be expanded?*

A37 Consumers are to be heavily involved at the local level in the initial planning, development, and ongoing governance of the SPEs. Four members of the LTC Commission are active in three of the state-level workgroups. These commissioners are consumers and represent consumers. It is the position of the OLTCSS that consumers can have the greatest impact participating at the local level, where operating processes and protocols are developed and implemented.

Q38 *Are you expanding to all Michigan counties and when?*

A38 The Legislature initially wants to keep the demonstration to the four identified service areas and requires an evaluation prior to expansion. Depending on successful outcomes, the initiative is planned to go statewide at the conclusion of the demonstration period in FY 2009.

Q39 *Mike mentioned that creating independent agencies is a national trend for SPE development. Can you identify some other states using this design?*

- A39** Florida passed single point of entry legislation that prohibits direct providers of service from being a SPE. Aging and Disability Resource Center grantees in AK, IA, LA, ME, NC, NM, and WV provide SPE functions but not waiver or other provider functions. New Hampshire and Wisconsin have detailed conflict of interest components; in Wisconsin, the Aging & Disability Resource Centers are separate from the Family Care plans.
- Q40** *In many of the past discussions about SPEs, the concept of no wrong door was changed to a single point of entry. Can you elaborate on your concept of no wrong door?*
- A40** The goal is that consumers, regardless of where they call or inquire, would receive good information and connection to staff from the SPE. This is achieved through communication and shared training offered in SPE regions.
- Q41** *Can you create a website for posting all kinds of materials from the SPE demonstrations, Commission, PCP Action League, Legislature, etc.?*
- A41** A website has been created at www.michigan.gov/ltc to keep interested parties informed about Commission and Office activities, SPE demonstration projects, and other related long term care systems change issues. A page with SPE demonstration project information and updates will be available in the very near future.
- Q42** *Can we get copies of today's power point presentations?*
- A42** Copies are available at www.michigan.gov/ltc.

Michigan Department
of Community Health



Jennifer M. Granholm, Governor
Janet Olszewski, Director

YOU ARE INVITED TO ATTEND
THE
SECOND “SINGLE POINT OF ENTRY”
INFORMATIONAL FORUM
MONDAY, SEPTEMBER 25, 2006

AT THE
Capital View Building
Conference Room A, B, C
210 Townsend Street, Lansing, Michigan

10:00 am – Noon

An informational session for stakeholders and persons interested in learning about the newly forming Single Point of Entry for long-term care services in Michigan. Presentations will be followed by a question and answer period.

FUTURE MEETINGS:

October 23, Michigan Home Health Association

10:00 am - Noon

2140 University Drive, Suite 220, Okemos, Michigan (517) 349-8089

November 27, Michigan Library & Historical Center, Auditorium

10am - Noon

702 West Kalamazoo, Lansing, Michigan

Sponsored by the Office of Long-Term Care Supports & Services
Michigan Department of Community Health

For More Information: 517.373.3860 or thelen@michigan.gov **RSVP not required.**

The Single Point of Entry will be a highly-visible and trusted source of information and assistance about long-term care, aiding Michigan residents with planning and access to needed services & supports, in accordance with their preferences.

FOR IMMEDIATE RELEASE
Friday, Sept. 15, 2006

Contact: CMS Office of Public Affairs
(202) 690-6145

STATES GET FEDERAL GRANTS TO HELP PEOPLE WITH DISABILITIES LIVE IN THE COMMUNITY

HHS Secretary Mike Leavitt today awarded nearly \$20 million in grants to states to develop programs for people with disabilities or long term illnesses. The “Real Choice Systems Change Grants for Community Living” will help states and territories “rebalance” their long-term support programs to help people with chronic illness or disabilities to reside in their homes and participate fully in community life.

“These grants will help states take full advantage of the opportunities to reform their Medicaid long-term care systems offered by the recently passed Deficit Reduction Act of 2006 and remove barriers to equality for the 54 million Americans living with disabilities,” Secretary Leavitt said. “They will help persons with disabilities exercise meaningful choices about how and where to live their lives.”

The Bush Administration has promoted the goal of community living for people with disabilities through the *New Freedom Initiative*. Under this initiative 10 federal agencies have collaborated to remove barriers to community living. The additional funding for “Real Choice Systems Change Grants for Community Living” approved by Congress for 2006 will augment efforts begun in FY 2001 to help states improve their community-based services.

“The grants awarded today will help states make lasting improvements to their home and community based services programs,” said Mark B. McClellan, M.D., Ph.D., administrator of the Centers for Medicare & Medicaid Services (CMS). “This program is vital in helping Medicaid move from its institutional bias to a program that truly meets the needs of people who depend upon it.” The eight states receiving 2006 awards are; California, Virginia, Michigan, North Carolina, New York, New Jersey, Rhode Island and Kansas.

Since 2001, CMS has awarded 306 Real Choices grants, totaling approximately \$237 million to 50 states, Guam, the Northern Mariana Islands and the District of Columbia.

For this round of grant awards, CMS will require states receiving grant money to address at least three of the six goals necessary to transform Medicaid program incentives away from institutional care with options for care at home and in the community. The goals include:

- Improving access to information regarding the full range of community-based services available;
- Promulgation of more self-directed service delivery systems;
- Implementation of comprehensive quality management system;
- Development of information technology to support community living;
- Flexible financing arrangements that promote community living options; and
- Long-term supports coordinated with affordable and accessible housing.

By providing important support for rebalancing long-term care services, the Real Choice Systems Change program has paved the way for the much more extensive options now available to states since the passage of the Deficit Reduction Act of 2006 to help states create greater opportunities for community living. The centerpiece of these efforts is a major new funding opportunity for states through the Money Follows the Person Rebalancing Demonstration.

This demonstration provides up to \$1.75 billion to eligible states to transition individuals from institutions who want to live in the community and rebalance their entire long-term care system to ensure individuals have a choice of where they want to live and receive services. While applications for this demonstration are not due until Nov. 1, 35 states have expressed interest in applying.

For more information on the New Freedom Initiative, visit the CMS Web site at: <http://www.cms.hhs.gov/newfreedom/>.

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Note: All HHS press releases, fact sheets and other press materials are available at <http://www.hhs.gov/news>.



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[TIPS for Effective Techniques for Consumer Input at Task Force Meetings](#)

[Use of Language - Philosophy and State of Mind](#)

[Transitioning from Institutions- The role of community capacity building](#)

[Money Follows the Person and Minimum Data Set \(MDS\) Information](#)

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Basics of Medicaid: A Grassroots Advocate's Perspective

Medicaid is not that complicated. Medicaid does not have to be scary.



Don't be "CFR'ed" and fooled into thinking that you can't have input and can't have anything smart enough to say. Sometimes public officials and policy wonks use "insiders" language to make things seem overly complicated and mysterious. Most often, however, the problem is just that the policy people and state agency folks have simply forgotten how to communicate in plain language with the average person. Whichever the case may be, this can have the effect of keeping consumer advocates out of the loop.

Always speak up and demand that information be provided in a way that is understandable to you.

Here is some simple information about Medicaid that a non-professional, grass-roots advocate can use as a guide to understanding the basics of Medicaid for effective advocacy:

- 1. Medicaid is part of Social Security. Social Security is public health insurance and cash assistance program for people who do not work because they are retired or have a disability.**
- 2. Medicaid is basically a publicly funded health insurance program for low income people.**
- 3. Medicaid is a state/federal partnership funding source, not a service system or program. This means that Medicaid is a payment source for health care and long term services providers like doctors, hospitals, home health agencies and so on.**
- 4. "When you've seen one Medicaid program, you've seen one Medicaid program." - Lee Bezanson. Each state has a different, unique, Medicaid system/program. There really isn't a federal program. There are 50 different programs in 50 different states.**
- 5. The service packages, specific eligibility requirements, and**

populations served are set by the states inside of very broad federal guidelines. Most of any state's Medicaid services are optional and are not required by federal rules. The only required services are:

- Health care - doctor, hospital, health clinic & related nursing
- Nursing facility long term services
- Post acute home health
- Children's services o Maternity services Basic health care services account for most of the people served and most of the money spent.

6. Most of the services are optional. Some optional services are: Prescription drugs Transportation Assisted living Intermediate Care Facilities (i.e. ICF/MR) Vision Dental Hearing Mobility aides Home modifications Occupational or Physical Therapy Home and Community Based Service (HCBS) Waivers Personal Care Life line or other personal emergency response systems Other - yes there is an "other" category which can be almost anything as long as it serves a legitimate purpose, protects health and well being.

7. It is the "optional" services like HCBS waivers that get cut when state budget difficulties arise because they are not required by federal law. This means that states don't have to provide the service at all if they don't want to.

8. How much service, how many of people receive service, and what types of service is available, is generally up to the state, not the federal government. The services and who gets them are limited by the state's willingness to provide state matching funds.



9. The federal government matches at least 50% and may match up to 83% of state funds for the program. This means that for every dollar a state puts up, the federal government will throw in an additional one to about four dollars.

10. Find out what your state does with Medicaid. Each state must have an official "Medicaid State Plan" which details all of the state's services and programs funded by Medicaid. Get the plan. Read it. Be familiar with it and then you will be an expert in your state.

11. All services, whether optional or mandatory, have certain rules called "amount," "duration," and "scope." This means that services must be available in the same amount, the same way to all eligible people regardless of age or type of condition in all parts of the state.

12. The only exceptions to the amount, duration and scope requirements are "Targeted Case Management" and "Waivers." These two are specifically allowed to limit the "amount," "duration," and "scope" of services.

13. All services must meet a health or long term care need and must protect health and well being. What "protection of health and well being" actually means varies with each state and is often a point of serious controversy and debate. The results can be harmful, with unnecessary restrictions on consumer control.

14. Requirements for training, licensure and qualifications of service providers are up to the state and vary with each state.

Who uses Medicaid? Children are by far the largest recipients of Medicaid, followed by adults of families with children, people with disabilities and the elderly.

Final Thoughts: A trap to avoid is thinking that people's needs have to fit into a limited, particular, rigid program or set of services. People's needs are ever changing and unique. Creativity and flexibility are the keys to serving people under Medicaid or anything else. Medicaid will never be able to provide everything that is needed and so states must design Medicaid programs with an eye to coordination with other state, local and federal programs and services.

The main thing for consumer advocates to do is to clearly state what people need and want and then help the state figure out how to meet that need. The thing to avoid is trying to make people fit a program instead of the program flexibly fitting individuals.

Advocates should clearly state what is wanted as a goal and then work with state officials toward meeting the goal. Medicaid can be flexible and creative, if you and your state let it be!

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Medicaid Waivers, Not as Hard as You've Heard; You Just Check a Bunch of Boxes, The Hard Part is Picking the Box to Check

You have heard of Medicaid Waivers a/k/a "Waivers." You may have heard that they are complicated, take a long time to prepare and get approved and that they are hard to implement and monitor for quality and so on. There is some truth to these statements, but consumer advocates can easily understand and have an impact on Medicaid Waivers in the states. In fact, given that the vast majority of all home and community services and supports are provided by Waivers, it is very important that consumer advocates be heavily involved with the Waiver programs and services in their states.



1915(c) HCBS Waivers

These types of Medicaid Waivers are the most used method of providing home and community-based services and supports. Waivers can be very flexible and serve a narrow or targeted population such as people with brain injuries or AIDS only, or can be generic and serve broad categories such as elderly and people with disabilities. Waivers exist to serve people who otherwise qualify for institutional placement. To be eligible for a Waiver, you must be eligible for an institution such as nursing facility, intermediate care facility, brain injury hospital, rehabilitation facility or medical hospital.

The meaning of "waiver" is pretty basic. When something gets "waived," it means that a normal rule or requirement doesn't have to be followed. So with 1915(c) Waivers, the normal Medicaid rules that don't have to be followed are "state wideness," "comparability," income and resource standards, and equal provision of services. States have to ask the federal Medicaid agency called the Center for Medicaid/Medicare Services (CMS) to waive these requirements or allow the state to not have to follow these particular rules. These are the only rules that can be "waived." All other regular Medicaid rules have to be followed.

Definitions of the normal Medicaid rules:

State-wideness - All services a state provides must be provided everywhere in the state regardless of population density, rural location, etc. State-wideness means that services must be available to all citizens of the state who are eligible for the service, regardless of where they live.

Comparability - All services must compare equally regardless of who receives them or where they are delivered. This is similar to state wideness. For example, prescription drug coverage requires that what gets covered is the same whether the person is elderly or young, has a physical disability or a cognitive disability, or whether he or she lives in the county or the city.

Income and resource standards - How much money someone who gets Medicaid can make in month, whether earned at a job or received due to retirement or social security, and how much money you can save up. In other words:

Income = monthly check amount; and

Resource = how much money you can have in the bank.

Equal provision of services - This is a lot like comparability. The easiest example of equal provision is the rule that there can't be waiting lists for services or case management only while you wait for a full service slot.

Again, "Waiver" means that these four basic Medicaid rules don't have to be followed by a state if the federal Medicaid agency gives the state permission. This may sound like it may not be a good thing, but really Waivers can be a very good thing. Waivers are responsible for over a million people living at home and in their communities instead of institutions which is a very good thing!

All states have at least one Waiver now and most have several. Waivers

serve millions of people. There are about 250 Waivers now operating nationwide. Examples of targeted Waivers:

- Nursing Facility o Intermediate Care Facilities (ICF/MR, ICF/MI)
- AIDS
- Technology Dependent Children
- Brain Injury
- Severely Emotionally Disturbed
- Alzheimer's

Like the rest of Medicaid, states are in the driver's seat for most of the decision making such as who gets served and what services are provided. A state decides how many people to serve. There is no limit. The state decides how much it wants to spend and the federal government must match that amount at a rate that ranges from one dollar for every state dollar to about four dollars for every state dollar.

Waivers allow for consumer control or self direction / self determination. Waivers pay for various kinds of providers ranging from licensed health and social professionals such as RNs or social workers to unlicensed friends, neighbors and in certain cases, family members. Who can perform what kind of task or services is up to the state to decide. There are no federal provider standards as long as health and well being are protected.

All kinds of services and supports can be provided by a Waiver. Examples include:

- Case management & targeted case management
- Respite care o Private nursing
- Home health services
- Attendant services
- Home modifications
- Assistive technology
- Escort services
- Medical transportation
- Habilitation
- Vehicle modification
- Communication aides
- Caregiver training
- Transition from institutions
- Emergency response
- Other

Waivers do not pay cash assistance or pay for housing.

The largest group of people served on Waivers is people with physical disabilities of all ages (aging & disabled). This group constitutes about 60% of all people on Waiver services. This group spends about 25% of

all Waiver dollars.

The most money is spent on people labeled Developmentally Disabled. This means that a person acquired a disability before the age of 22. This group gets about 70% of all money spent and constitutes about 30% of the people served.

The rest of the money spent and people served is for folks with specific diagnoses such as TBI, AIDS, SED, etc.

Common Advocacy Issues

While these Waivers have been very popular with consumers, advocates and state officials, and they have grown tremendously in the past few years, recently state and federal officials have begun to worry about an outgrowth of this popularity - rapid and large cost increases. While Waivers are required to be cost effective, meaning they have to cost the same or less than the cost of putting people in institutions, they have become one of the most costly Medicaid services. In most states, Waivers are the first or second largest cost to the Medicaid program, right up there with prescription drugs. Basic health care like doctors and hospital expenses are still the largest cost for all states.



The related problems of growth in size and cost has caused many problems with growing waiting lists for services and services cut backs in almost every state. Advocates must be familiar with and ready to address the cost and growth problems in their states. These problems have caused many states to look at even more potentially flexible options for controlling growth and cost issues. One option is called "block granting." Related to the "block grant" concept is another type of Waiver that in the past year is increasingly being looked at by the state and federal governments called 1115(c) Waivers.

1115(c) Waivers will be explored in a future "Tips".

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TIPS for Effective Techniques for Consumer Input at Task Force Meetings

Overview

You are the Expert.

You are the Expert. You are the expert on your own experiences. *You* know what works well for you and your peers. You also know what the problems are and what needs to be improved. This very important knowledge that the "experts" don't have makes *you* an expert; an expert on living with a disability or long term illness and using services and supports. As "consumer experts", it is not our job to offer medical advice or therapy. It is not the purpose of the Real Choice Systems Change grants to treat or cure health conditions - to fix what's "wrong" with people. The purpose is to "fix" the systems to meet people's needs.



Share your Expertise.

Your job is to share your expertise with the rest of the Task Force so that state programs and services can be improved to better meet everyone's needs and to promote independence of people, and the openness, usefulness and accessibility of the communities we live in and belong in.

Before the Meetings

- Come prepared. Read the minutes and other materials before the meeting and jot down any questions or issues about the materials.

Stay in touch with other taskforce members to see what they are thinking, share ideas, problems and strategies in between meetings.



- **Contact the meeting facilitator / coordinator in between, or before, meetings to ask complicated questions or to get more in depth explanations. Ask for issues and problems to be put onto the agenda before the meeting starts**
- **Don't worry so much if you're not a "policy wonk" and if you don't know all of the rules and regulations. Your expertise is your experience. Know and be assertive about what needs to be improved and what you want. The policy expert's job is to figure out the way to make the system meet your needs.**
- **Think of your role on the task force as that of a representative of a group - IL, Aging, DD, Mental Health, etc. Ask others from your group to give ideas and buy-in to guide your advocacy.**

Now that you are ready for the meeting, here are some ideas to keep in mind

At the Meeting

- **Show up on time. Be ready to work.**



- Be brief and clear in your remarks. Consider writing up notes and practicing what you need to say. If you ramble on and on, you may lose other people's interest in your important issues.
- Ask that jargon and acronyms not be used. Insist on "people first" language that avoids complicated sentences and big, unusual words.
- Be respectful of other people and opinions. Let others speak. Take turns. Don't let any one person (s) "filibuster" the meeting by talking all time and "hogging" the show.
- Insist on everyone having a chance to voice an opinion.
- Don't be rushed. If an issue or problem needs more time to get resolved, ask for more time. Consider writing down important issues or information and sharing them with the group in writing.
- Don't take "no" for the first answer. If there is a will, there is a way! Most state and federal systems are more flexible now than ever in the past. The problem is almost always political will and enough money in the state budget.
- Never agree to something that doesn't feel or sound right. Don't be pressured to go along.

You have prepared for the meeting and just finished participating in it. What next -

After or in between meetings:

If you have volunteered to do something, make sure and finish your assignment. Others are counting on you. Ask for help from other task force members and the coordinator if needed.

Stay in touch with the "advocacy group" you represent. Share the minutes, notes, etc. with others in the community so they are included. Many times this is an excellent way to get good ideas and issues or problems you may not have thought of yourself.

Read all materials that you can and think about your issues and ideas. Jot down notes so you don't forget your great ideas. Sometimes it is hard to be thorough and careful when under pressure at a meeting when people are watching, waiting, and time is short. Use the time in between meetings for creative thinking when you are not under pressure.

General tips for sharing ideas or presenting to a group

- **Don't attack people with name calling that is off target.**
- **Stick to one issue at a time. Solving all the problems of the world in one speech will be too confusing and lose people.**
- **Avoid arguing. Take turns. Don't interrupt others or let them interrupt you.**
- **Don't bluff. If you don't know something, say so.**
- **If you bring written materials to share, don't overload people with tons of paper. Too much paper sometimes makes people not want to read any of it.**



- **Remember to represent others. It is much more powerful when you can share many people's or an organization's ideas and issues than just your own personal opinion.**

- **Never give up. The purpose of the project is to give real people a real voice and real choices and real control over real lives. This is your project. Make the needed changes happen!**

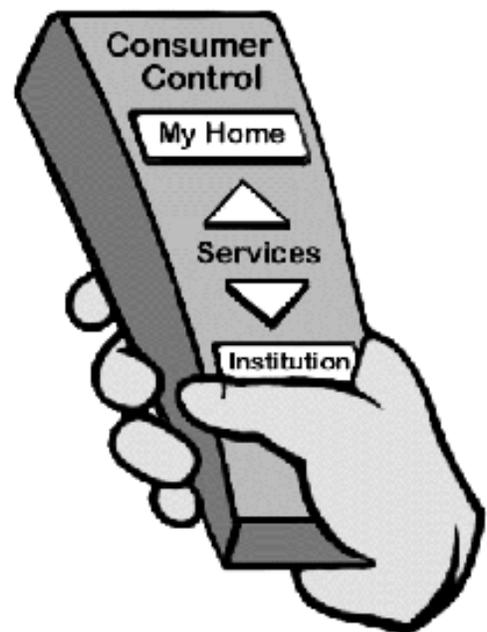
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Use of Language - Philosophy and State of Mind

State and federal governments want budget efficiency and to contain costs. They want "budget certainty." Government seeks to change systems of financing. They seek a way to achieve this goal through "cost caps," "block grants," "global budget caps," and "managed care" by changing the ways that essential services are paid for. Part of the lure of these new systems is the idea that they would be flexible without a lot of federal rules and without mandatory services or programs called entitlements.

As consumer advocates whose job it is to advise and oversee various Real Choice System Change projects, we need to be crystal clear about the goal of real choice systems change and what these four words mean to us. Different meanings can lead to conflicting goals and this is a huge problem.

For consumer advocates, Real Choice systems change must result in the following:



- **Individuals actually have control over the programs and services provided for their benefit. This control must be "official" and form**

permanent policy, regulations and laws.

- **Regardless of age, diagnosis or label, people have a right to choose to leave institutions and to receive adequate, quality supports and services in the home and community setting of their choice without long waits.**
- **People actually exercise this choice and leave institutions.**
- **People have the right to choose to receive home and community services and supports BEFORE they have to go to an institution.**

Systems change for government and systems change for consumer advocates are not necessarily the same thing. On the other hand, they can work together. For decades, for example, advocates have noted that home and community services with consumer control features do save money; they cost one-third to one-half as much as institutions. It is our job as advocates to make sure that changes to systems that pay for and regulate long term services and supports also promote and protect the freedom, dignity, and legal rights of seniors and people with disabilities.



All of the research, publications, manuals, PowerPoint® presentations, trainings, etc. that are being produced by Real Choice System Change grants should result in consumer choice and control. If not, real choice systems change is not happening. Research, manuals, trainings, etc. are tools to achieve real choice systems change, but these things are not the real choice systems change itself.

Control over adequate supports and services, the right to choose to live in your own home and community, or the right to even decide what

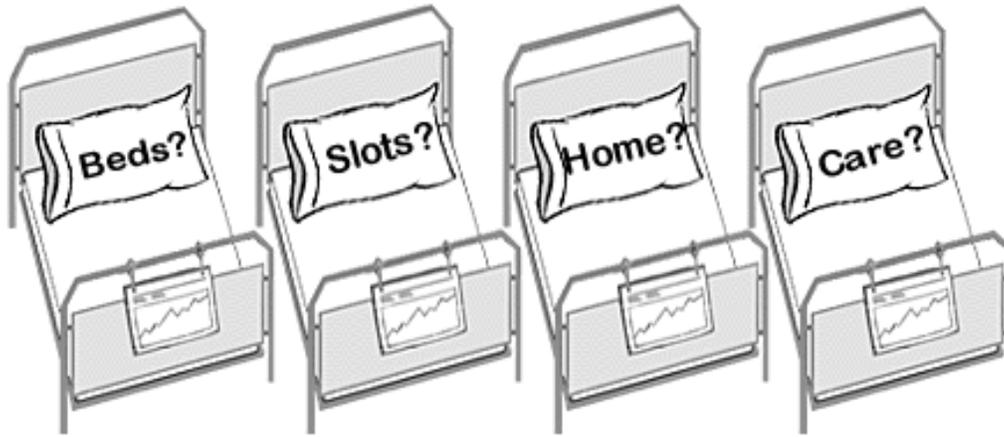
"home and community" means, are all signs of basic freedoms, civil liberties and non-segregation. The Olmstead decision, "consumer control," "self-determination," and "self direction" are not programs or service models or options reserved for some folks of certain ages or diagnoses. These are tools, ideas and philosophies that promote and protect the freedom and civil liberties of senior citizens and individuals with disabilities. Real Choice Systems Change means freedom and liberty for all seniors and people with disabilities.

Here is the "logic model" of Real Choice Systems Change from a consumer advocate perspective:

**Real Choice Systems Change = Laws,
regulations and policies that govern services
and programs so that they promotion and
protect freedom and civil liberties of people
with disabilities and seniors.**

We have to be careful not to get sidetracked by medical model language, jargon and related philosophy. This can be quite difficult; harder than it seems, especially at meetings with professionals, state and grant officials. There are a couple of reasons for this. The first reason is just to be understood. The second reason is to try to "fit in" and appear to be as knowledgeable and professional as everyone else. Language is very important. It reflects philosophy, state of mind, and a fundamental understanding of the purpose for real choice systems change.

"Beds," "slots," number of "beds" in a "home," "allowing to choose," "care for," are terms that continue to pop up as part of Real Choice projects around the country. Real choice must mean that seniors and individuals with disabilities have a right to not be an object of someone else's "care," professional attention, or control. Home and community does not mean that the only living non-institutional option is a group home, or a place with a "home like" atmosphere. The issue is whether each person has control over decisions and the meaning of home and community. As long as individuals have to fit into beds, slots, programs, etc., then real choice does not exist and systems have not changed.



As advocacy task force members and advisors we must remember to teach and, finally, assert control over language and philosophy. Why? How we talk reflects how we think and what we believe. Freedom, liberty and independence are a state of mind. Seniors, individuals with disabilities and those who choose to support us, decide whether we're free, not providers, not professionals and not programs.

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Transitioning from Institutions- The role of community capacity building

According to Multiple Data Set (MDS) information published by the Center for Medicare/Medicaid Services (CMS), about 274,000 people residing in nursing facilities could potentially live in their own homes and communities. Taking into account people with DD labels residing in various types of institutional facilities, the number of individuals who could benefit from, and who would like, home and community alternatives, this number is well over 300,000 people. The point is that there are a lot of people who could live better lives outside of institutions. This means that institutional transition services need to be

not only continued, but expanded dramatically, regardless of changes to the Medicaid program, state budget woes, or whether Real Choice Systems Change Grant funding is available in the future or not.



Community agencies must play a key role in transition.

Centers for Independent Living¹ provide examples of federally (and state) funded entities that provide various community services to individuals, without regard to type or nature of disability or age. These entities have a major interest, if not requirement, to assist people with civil and human rights, and to help people access various services and supports. The word "community" has been underlined because discussion will return to it. The meaning and role of community is often not fully understood, is underemphasized, and is underutilized in formal transition services and programs.

- *What is a community?*
- *What does it look like?*
- *How does a community benefit its members and its members benefit it?*

These are not just interesting philosophical questions, but rather contain the key to successful transition and integration into community living.

Transition services and programs are usually linked to particular populations or groups to be served and are used in isolation - as the end all / be all for that group, e.g. transition for elderly onto an "aging" waiver, or transition for physically disabled onto a physical disability waiver, etc. If a person doesn't fit the label, no help is available; if the waiver doesn't provide a needed service, then the person isn't eligible to move out. This unnecessarily and artificially limits people's options, ignores other available community resources, and can keep people segregated and isolated from their communities even when supposedly living in the community and receiving so-called community services. In the end, this problem keeps people from benefiting from the whole community and keeps the community from benefiting from all of its members.



Personal Assistance



Bus Services



Banking



Shopping



Housing



Cooking



School

A recent discussion with a friend from Georgia brought up some very interesting data that speaks to the issue of "community" and unnecessary service and program limitations. Georgia has had a Real Choice NF transition grant and during the past year or so, 124 people have moved out of facilities into their own home and communities. Great news and a very successful project! The IL community (CILS and the SILC) have been key to making this success. Along the way, as it happens, of the 124 people who moved out, 47 didn't need ongoing (Waiver) supports and services. They just needed the initial, up front transition assistance, including home modifications to make a successful move. These folks continue to benefit from and add to their communities with what are known as "informal" and "natural" supports. Community integration and informal and natural support, in this respect, come to mean the same thing and clearly, as this example demonstrates, are key to success, though often overlooked. In other words, the most successful integration occurs when an individual uses the same "natural" services and supports available in a given community that everybody else uses, as opposed to only using "special," separate services and programs.

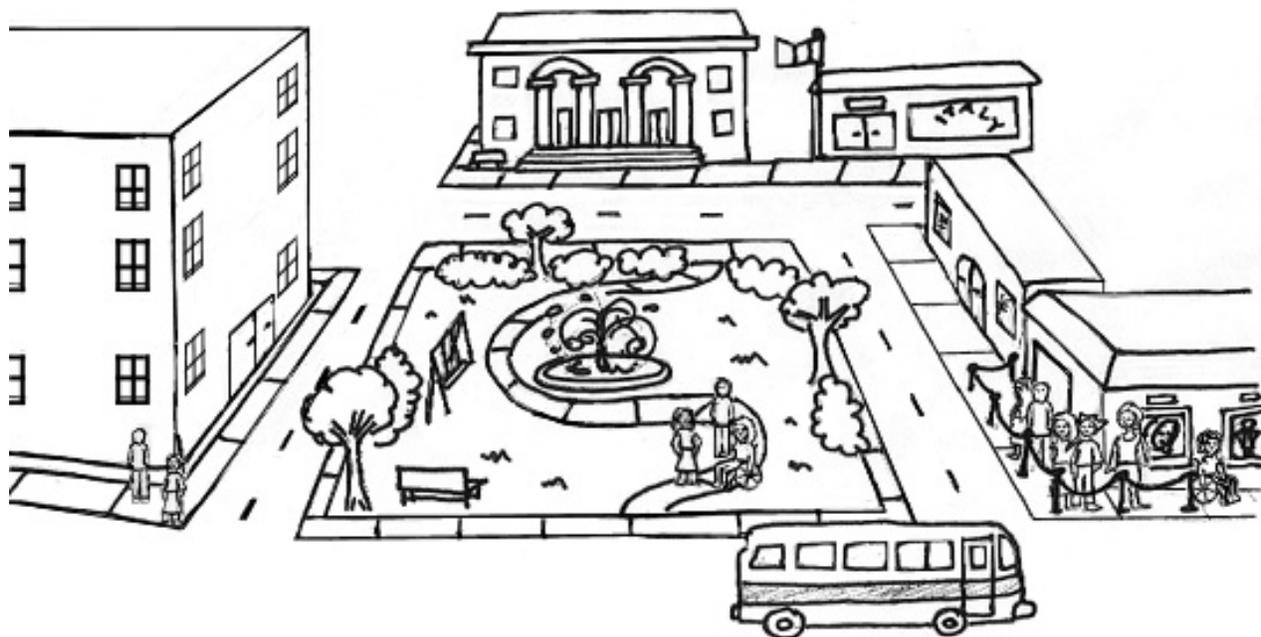
Integration succeeds when an individual uses the same "natural" services and supports available in a given community that everyone else uses.

A community is a place where there are people of different ages, from babies to grandparents; a community is a place where people have things in common to share. Recreation, religion, work, health care, food and water, housing, transportation, and so on happen in communities. People leaving institutions must have these things available like anyone else. Community agencies like CILs help people access these without regard to a special program for a special population. Without regard to coming from an institution, a CIL builds a sense of community by answering questions: *What do I do when my car breaks down or when I need a ride? What happens when I get sick? What happens... When I run out of money? Have utilities break down? Need a job? Have trouble with a landlord? When my worker doesn't show up? Etc. etc.*

CILs help explain what a given community is, what is available, and how it works. This creates an environment where folks feel comfortable. People who work with a CIL help each other all the time, without thinking about the help being equivalent to a program or service model.

Capacity of communities is also built and increased by making sure that

whatever is out there in a given community is available to everyone and anyone, regardless of type or severity of disability, age, or medical diagnosis. This is what CILs stand for without regard to whether you've moved from an institution. Communities are better than, more permanent and more integrated than any program, service, waiver or case management system. Successful transition must look to the community as a whole and should build capacity of communities naturally through interaction with all of the community's members, and all of its components from jobs, to fun, to shopping to ...



In the end, we don't *just* need more and more specialized programs and services. We need communities that are accessible to anyone and that include everyone. Perhaps it is time to begin thinking of specialized programs and services as a means, as a stepping stone along the way toward the end goal of accessible, integrated, inclusive communities.

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Money Follows the Person and Minimum Data Set (MDS) Information

Integrating advocacy activities as a route to promoting real choice in long term services and supports.

MFP & MDS

Many advocates are familiar with Money Follows the Person (MFP) and potential benefit of Minimum Data Set (MDS) information. There has been a fair amount of information and discussion over the past couple of years around these two issues. Organizations such as SteveGoldADA, ADAPT, and NCIL have provided information and advocacy related to these two issues. Consumer Task force advisors to Real Choice Systems Change Grant projects may want to consider advocating for these two issues together to create a unified system for identifying people who prefer home and community alternatives to institutions, and then implementing a program to assist those who actually want to move out.

Minimum Data Set (MDS) information is a good place to start when getting a rough idea of how many people may prefer a home and community option. MDS information may be useful in creating a cost/program size estimate, but it is not a fine enough predictive tool to rely on for actually determining who will end up leaving institutions. It's just a good place to start.

"Money Follows the Person" (MFP) can create a program or service model for providing the actual hands-on assistance, information and referrals that people need to successfully relocate from the institution to their own homes and communities. Together, the use of MDS information and implementation of MFP can create a comprehensive system for real choice and Olmstead compliance. After all, if you obtain a Money Follows option at the state level, where do you start and how do you find people who may want to use the program? On the other hand, finding people who want out, but not having a service system or program in place to honor and implement that desire only leads to frustrated hopes.

This Tips paper looks at the two concepts to give advocates a basic familiarity and how the two can work together to achieve a better system for real choice for aging folks and people with

disabilities.

Money Follows the Person



State Responses

MFP is actually not a particularly new concept. It began in the DD system many years ago for people coming out of the large Intermediate Care Facilities (ICFs) and state hospitals. A couple of years ago, Duane French, a well-known IL advocate, pointed out that Alaska began a money follows project there twenty years ago for the people labeled "DD" coming out of institutions. Money Follows the Person for people in nursing facilities; however, is a relatively new phenomenon that started in Texas about four years ago.

Advocates in Texas convinced their state legislature to add a "rider" to their health and social services budget bill that created a mechanism for the dollars budgeted to pay for an individual to stay in an NF to flow from the NF budget to the Waiver budget if that individual moved from the NF to a Waiver. This allowed people currently being funded for Long Term Care (LTC) in an NF to receive LTC in the community without going on to a waiting list and without requiring new, additional budgeted expenditures for the Medicaid Waiver. Since its inception, this program has allowed 3,200 people to move out without increasing LTC budget expenditures overall. In fact, it has saved money because the average plan in the community costs less than the average NF. Kansas followed suit a year later with a much more modest program, allowing over 300 people to move with a budget-neutral impact. Other states that have followed suit at the state level include Pennsylvania.

Federal Initiatives

There have been a couple of initiatives at the federal level that stem from the work begun in Texas at the state level. The first is part of the

President's New Freedom Initiatives to swiftly implement the Olmstead decision. The President and his administration through CMS have been promoting Money Follows the Person in the form of technical assistance and information. See, for example, the "Dear Medicaid Director" letter dated 8-17-04, (SMDL #04-005), encouraging states to take action. The administration has also budgeted money in past years for federal legislative initiatives to pay for transition costs and for 100% of an individual's first year's cost of community services. After the first year, the state would pick up the costs via a federally matched Waiver or PCO. In 2004 there was also legislation at the federal level in the form of HR 1811, which was the Family Opportunity Act and Money Follows.

In this new, current Congress, Senator Tom Harkin has introduced S 528, Money Follows the Person Act, which would cover 100% of the first year's cost for an individual once that person moved out into the community. The President's Budget for FY06 also has money set aside for Money Follows the Person (see below).

DEPARTMENT OF HEALTH AND HUMAN SERVICES



AT A GLANCE:

2006 Discretionary Budget
Authority: \$67.2 billion (Decrease
from 2005: 1 percent)

Major Programs:

Medicare

Medicaid

**State Children's Health Insurance
Program**

Health Centers

**Marriage and Healthy Family
Development**

Bioterrorism

Health Care Information Technology

MEETING PRESIDENTIAL GOALS

Promoting Economic Opportunity and Ownership

Money Follows the Person Rebalancing Demonstration. This five-year demonstration would finance Medicaid services for individuals who transition from institutions to the community. Federal grant funds would pay the full cost of home and community-based waiver services for one year of a beneficiary's care, after which the State would agree to continue this care at the regular Medicaid matching rate.

The President's budget appears to pertain to legislation that still needs to be introduced, perhaps by Senator Grassley. Federal funds would be a big help to the states and to advocates in getting funding to help people reintegrate back to the community, but still consider advocating at the state level now to do a Money Follows project like Texas did.

Successful reintegration from institutions takes more than money, more than available Waivers or PCOs. How do we identify people? How many are interested? Where are people residing now? What are they like? What might their needs be? Answers to these kinds of questions are critical to planning and implementing effective transition programs and services. A place to start may be the MDS information.

MDS Information

MDS can provide information state-by-state, by facility, by name, by age, health status, etc. who may be interested and appropriate for leaving the NF and going home to the community.

- Basic public information can be found by doing the following:
- Type the word Medicaid into your search engine.
- Click on the Medicaid home page.
- Next click on "Information for States and Territories".
- Next click the "Minimum Data Set (MDS) 2.0 Information Site".
- Next click on "Public Use Reports".
- Go to the bottom of the page and select "Report Type:"
- "Active Resident Information Report" and click "Submit". " Go to the bottom of the page and click "Submit" again (It should show the most recent quarter's data for selection, i.e. 3rd quarter 2004).
- Scroll down on the variables to section Q 1a, etc.

Consider working with state officials to use MDS, Section Q information in combination with Money Follows the Person to determine who to contact about home and community alternatives, to estimate numbers who may need services, and to estimate possible costs and cost avoidance over time. CMS, in a recent policy letter to State Medicaid Directors, outlined methods to access and use MDS information:

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS	
1. DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes
	b. Resident has a support person who is positive towards discharge 0. No 1. Yes
	c. Stay projected to be of short duration

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland
21244-1850
Center for Medicaid and State Operations

DATE: February 18, 2005
TO: State Medicaid Agency Directors
FROM: Director
Survey and Certification Group
Director
Disabled and Elderly Health Programs Group

SUBJECT: Release of Long Term Care Minimum Data Set (LTC/MDS) Data to State Medicaid Agencies, Section 1915 Waiver Programs, and "Real Choice Systems Change Grant" Programs in Order to Assist States' Title II, Americans with Disabilities Act (ADA) Compliance Activities.

Letter Summary

- **This letter provides guidance on CMS disclosure of LTC/MDS data to State Medicaid Agencies, Section 1915 Waiver Programs, and "Real Choice Systems Change Grant" Programs in order to assist states in their efforts to comply with the integrated care setting and reasonable accommodation requirements of Title II of the ADA.**
- **This letter should be shared with appropriate state agency staff and designated entities that are working on waiver and grant programs.**

Background

The Centers for Medicare & Medicaid Services (CMS) and its state partners have made important strides in identifying and eliminating barriers to community living. Many states are developing and implementing service delivery, financing, and administrative mechanisms to prevent and correct inappropriate placement of individuals in institutions and ensure adequate community supports. By allowing states access to LTC/MDS data, State Medicaid Agencies, Section 1915 Waiver programs, and Real Choice Systems Change Grant Programs can identify and transition LTC residents who would like to, and could appropriately be placed in the community. These ADA requirements have been clarified by the Supreme Court in *Olmstead v. L. C.*, 527 U.S. 581 (1999). For a more detailed discussion of how states might utilize LTC/MDS data to further their *Olmstead* and ADA programs, please find "In Brief.....Using the Minimum Data Set to Facilitate Nursing Home Transition" available at www.communitylivingta.info. This site is funded via a Real Choice Systems Change Grant from CMS to the Community Living Exchange Collaborative. The purpose of this grant is to provide technical assistance to grantees, including facilitating the sharing of information across states. This site is administered by Boston College on behalf of the Community Living Exchange Collaborative.

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Data collected through the LTC/MDS is maintained by CMS in accordance with the Privacy Act of 1974. The Privacy Act limits the disclosure of individually-identifiable information held by Federal agencies and permits disclosure of such information only when the purpose of the disclosure is one of the bases for the data collection's establishment, and for specific "routine uses." These "routine uses" are listed in a published (via the Federal Register) System of Records Notice. Routine

uses include various purposes such as administration of the Survey and Certification Program, and payment of LTC services, which include skilled nursing facilities (SNFs), nursing facilities (NFs), SNF/NFs, and hospital swing beds, and to study the effectiveness and quality of care provided in those facilities. Under the Privacy Act provisions, states and/or CMS are required to track disclosures of LTC/MDS data at the beneficiary level. LTC/MDS data releases may be tracked by the state or by CMS.

Use of MDS Data for Compliance with Title II Requirements

If the conditions discussed in this letter are met by the execution of a data use agreement (DUA), CMS will provide State Medicaid Agencies with LTC/MDS data on the residents of that state and beneficiaries of that State's Medicaid program. One purpose of such use is to assist states in their efforts to comply with the integrated care setting and reasonable accommodation requirements of Title II of the ADA. CMS believes that the LTC/MDS data will help states and designated entities identify residents with disabilities who have a desire to live in the community, and will provide information related to the level of services necessary to fulfill states' ADA requirements in relation to such individuals.

In an effort to further assist states in ADA compliance activities, CMS has developed a report providing aggregated current resident responses to the LTC/MDS Section Q1a. The report provides state, and more importantly, county level information on resident responses. This data is available on the CMS Web site at <http://www.qtso.com/mdsdownload.html> and is updated quarterly.

Obtaining MDS Data

CMS will allow State Medicaid Agencies or designated entities access to LTC/MDS data on the residents and Medicaid beneficiaries of that state after it receives and approves a Medicaid Data Use Agreement (MDUA) from the state. The MDUA must be signed by the requestor and the custodian of the data and binds the parties to the requirements of the Privacy Act and the applicable LTC/MDS System of Records. CMS has prepared the updated MDUA with ADA provisions and revised the Addendum sheet to include Title II ADA activities. The required forms and other information can be accessed at www.cms.hhs.gov/privacyact/requests. Completed MDUAs should be submitted to the Regional Office MDS representative for review and approval. States that execute a new or updated MDUA may obtain all state-specific LTC/MDS data for purposes listed in #6 of the MDUA, which include activities aimed at ensuring state compliance with the requirements set forth in Title II of the ADA.

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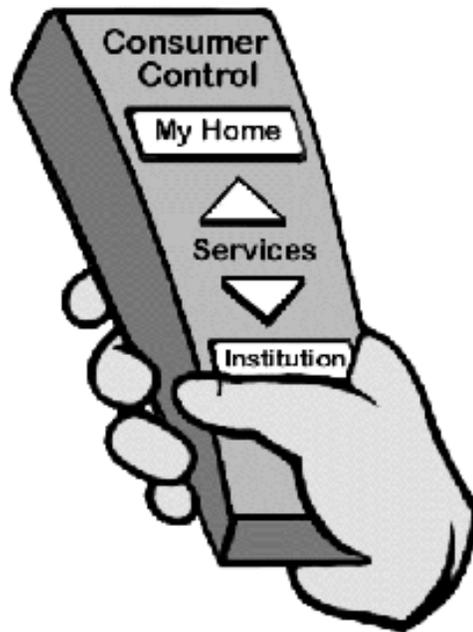
States that request the LTC/MDS data for purposes outside those specified in the MDUA must request a Standard DUA. The Standard DUA is an open-ended agreement that allows the requestor to request LTC/MDS data for other uses. Those uses are also subject to the limitations on use and disclosure of individually identifiable information held in the LTC/MDS System of Records. States that have already submitted a MDUA for access to the LTC/MDS data may update those agreements to allow for the use of LTC/MDS data in ADA compliance programs. States should complete the Addendum sheet to reflect the custodian's information, signature, and additional use for ADA purposes.

State Medicaid Agencies with new or updated MDUAs and tracking mechanisms may obtain all state-specific LTC/MDS data. States that require assistance with the extraction of data will be charged a fee for each year of MDS data requested.

Technical Assistance

States that have not executed an MDUA and require technical assistance to establish how to comply with tracking requirements may contact Karen Edrington of CMS' Division of National Systems at 410-786-2166 or by email at kedrington@cms.hhs.gov.

Thomas E. Hamilton
Gale Arden



In conclusion, MDS and Money Follows the Person are two initiatives that can be pursued right now at the state level of systems change advocacy work. Combining use of MDS information with Money Follows the Person initiatives could create a powerful institutional transition program that systematically identifies, informs and assists people with rejoining their communities.

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How-To for the Medicare Part D Maze Tips for Consumer Advocates

The new Medicare prescription drug benefit is now in full swing all over the country. People with all kinds of disabilities and the aging community who are Social Security beneficiaries, including the "dual-eligibles" who have been receiving their prescriptions through Medicaid are dealing with a brand new system. For many, the new system can be confusing and difficult. This Real Choice "Tips" is presented to provide assistance for those who may be having difficulty, and for those individuals and agencies that are providing assistance to beneficiaries. The outline, below, has been tested and is in actual use. Hopefully, it will help. If anyone has any comments, ideas, or other rubber-meets-the-road practices in use that this project could share with the national "Real Choice" consumer advocate community, please send them along so they can be shared. Thanks, Mike Oxford

How-To for the Medicare Part D Maze Tips for Consumer Advocates

1. Get a print-out of the monthly prescriptions. This can be obtained from the pharmacy a person has been using. Be sure that the print-out includes the dosage amount and the quantity.



2. Once you have this list, go to <http://www.medicare.gov/>. Select the link for the "Formulary Finder." Select your State from the drop-down menu. Click on the "Continue" button. Enter the name of the first drug and click "Search for Drug." Review the drug on the list to be sure that the correct drug has been added; if there are more drugs, click on "Add Additional Drugs." A note: some drugs have different versions. For example, some drugs have a regular version and then a version with an "HCL." When this is the case, you will have to select the correct version of the drug from a list.

3. Once all of the required drugs have been listed, click on the "Continue with Selected Drugs" button. To be safe, I have then selected the button that says "Choose Drug Dosage." Follow the same basic process as with entering the drug names by selecting dosage amounts from the drop-

down menus. This is important because some drugs are available from formularies at a lower strength, but not at the higher dosage; for example a drug may be listed at 20 mg, but not at 100 mg. Once the dosage and amounts have been entered, select the "Continue with Selected Drugs" button.

4. This will generate lists of the formulary plans that provide coverage for all or for some of the prescription drugs entered on the previous pages. I have selected the "all" option from the drop-down list of plans per page, which allows me to print off the list of all of the plans at one time.

5. From this list, call the pharmacy and ask them to tell you which plans they will be accepting. Delete the plans they will not be accepting from the list. It is important to note two things if a needed or currently prescribed drug is not covered:



a) If a person uses a drug that is not covered on a formulary, the pharmacy is supposed to provide the drug ONE more time and ensure that guidance is provided as to what to do in future, and

b) If a drug is needed but not covered, there is an "exceptions" policy in place. This policy requires a person to be allowed to ask for an exception to a formulary's lack of coverage of a given drug. An answer to an exception request must be provided within 72 hours under normal circumstances and 24 hours if there is a crisis requiring an "expedited" request. The pharmacy is supposed to help with filing an exception and an expedited exception.

6. Return to the <http://www.medicare.gov/> website. This time, select the "Compare Medicare Prescription Drug Plans" link. From the next page, select the orange arrow to the right of the "Find a Medicare Prescription Drug Plan" heading. The direct link to this page is: <https://>

www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/Questions.asp

7. Go to the "General Search" button. Enter the zip code, mark current prescription drug coverage through Medicaid (top box) and select "Yes" under "Qualify for Additional Help". This same procedure is true if a person has other types of coverage besides Medicaid. Then, indicate the source of the letter as "Medicare," and finally select the type of letter, "Medicare and Medicaid" or whatever is appropriate. Select "Continue".

This same general procedure is true for other circumstances for people not Medicaid eligible, or who may be newly covered by the Part D program. Just choose the appropriate category and select "Continue" at the bottom of the page.

8. The next page will provide a listing of all of the plans for the type of beneficiaries (Dual eligible or just Medicare) for the zip code listed. You can arrange this list by name or by premium amount and look for the plans on the original list that the pharmacy says they will accept. The number in the second column is the dollar amount of the premium, which I assume is the amount that a beneficiary will be required to pay per month for coverage under the plan.

9. If you need help or if you get stuck, please ask for help. As most of us know, prescription drug coverage is vitally important to all of us. There could be increased expenses through the per-prescription co-payments of \$1 - \$3, for example. If this is a problem, it may be possible to identify cost savings in other areas, such as the monthly premiums.

10. Getting help if you need it is critical. If you do not have a computer at home, go to the nearest public library and ask to use theirs. Community agencies such as Area Agencies on Aging, Centers for Independent Living, Developmental Disability Agencies, Community Mental Health Centers, and state Medicaid, state Social Services, state Rehabilitation Services, etc. are potential sources of assistance. They can let you use their computers or look up the information for you.



11. Other issues that can spring up include not being able to find your drug on any plan (See number 5. above), or difficulty with paying any increased cost of any option, especially if you are a Medicaid recipient or have a low income. Think about getting professional advocacy assistance, immediately. Centers for Independent Living, Area Agency on Aging, and state Protection and Advocacy Services, also called Disability Rights Centers may be able to help. You should also contact your state Medicaid agency and talk to your case worker. Consider talking to your doctor and pharmacist, as well, to see if there are other possibilities including free samples or reduced cost / donation programs.

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